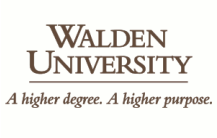

2019

Risk-Taking Behaviors of First-Generation Sub-Saharan African-Born U.S. Resident Men

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This is to certify that the doctoral dissertation by

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Abstract Title Page

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by

Henry K. Sinyangwe

MS, Thomas Jefferson University, 2008

BS, Widener University, 2004

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health

Walden University

August 2019

Abstract

African-born residents of the United States have a higher incidence of HIV than African Americans. Factors such as lifestyle, habits, behavior practices, and activities may predispose African-born residents to behave sexually in ways that place them at risk of becoming infected with HIV. This study used a qualitative narrative approach to understand the lived experiences first generation Sub-Saharan African-born men who are U.S. residents to analyze the behaviors that expose them to HIV. To analyze data, the study used the health-belief model as the conceptual framework and NVivo for data analysis to assist in identifying, categorizing, and analyzing common themes and grouping unstructured data. The study used a purposive convenience sampling of 14 first generation Sub-Saharan African-born men who are U.S. residents residing in the states of Delaware, New Jersey, and Pennsylvania and discovered that they engage in sexual risk taking behaviors which include: having multiple sexual partners, preferring heterosexual relationships without a condom, have limited knowledge of HIV prevalence in the United States, and preferring to have sex with both African born females and American born women who are thought to be healthy. Their tendency to visit strip clubs, visit sex houses, and to abuse alcohol was also apparent in the study. Social change implications include adding new relevant knowledge in the understanding of how HIV spreads among Sub-Saharan African-born male U.S. residents by discovering the risk behaviors in which Sub-Saharan African men engage to expose themselves to contracting HIV disease. This knowledge can influence future health education efforts and target culture specific behaviors.

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Dedication

This dissertation could not have been possible without the courageous first-generation male Sub-Saharan African-born U.S. residents who participated in the interviews that led to the publication of this research paper. Their lives, though entangled in tough transitions, create a fabric of learning of culture and tradition in a place that is so far from home. We celebrate their tenacious spirit.

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Chapter 1: Introduction to the Study

HIV incidence rates have increased among African Americans; however, according to the Centers for Disease Control and Prevention (CDC, 2011) the rise in HIV among African Americans cannot be attributed to U.S.-born African Americans; rather, the increased incidence rate can also be attributed to African immigrants. According to the Joint United Program on HIV/AIDS (World Health Organization [WHO], 2011), Sub-Saharan Africa has approximately 10% of the world's population, yet is home to 70% of all people living with HIV. In 2003, an estimated 3 million people became newly infected with HIV, whereas 2.2 million people died of AIDS. Of the estimated 10 million young people aged 15–24 years living with HIV worldwide, 62% reside in Sub-Saharan Africa. More than 11 million children under the age of 15 years in Sub-Saharan Africa have lost at least one parent to HIV/AIDS. In Sub-Saharan Africa, the most affected countries are southern African countries: Lesotho (31.7% of the population is infected), Zimbabwe (24.6%), South Africa (21.5%), Namibia (21.3%), and Zambia (16.5%). In each of these countries, the HIV epidemic is generalized and reaches all segments of society, rather than being confined to select populations (WHO, 2011).

The World Health Organization (2011) identified that heterosexual transmission is the predominant mode of HIV transmission: 57% of HIV-infected adults are women and 75% of young people infected are women and girls. In Sub-Saharan Africa, the factors that influence the HIV incidence rate include poverty, social instability, high levels of sexually transmitted infection (STI), the low status of women, lack of access to

prevention efforts, an inadequate public health infrastructure, stigma, and discrimination (WHO, 2011).

The current study investigated how HIV/AIDS is transmitted to immigrant men from Sub-Saharan Africa living in the United States 20 years of age and older. The current study comprised narrative qualitative research to analyze behavioral activities and factors that expose Sub-Saharan African male immigrants to HIV in the United States. To gather information for the study, the research design used interviews and asked Sub-Saharan male African immigrants for behavioral narratives about activities that exposed them to HIV. The participant sample for the study was 14 Sub-Saharan African immigrants 20 years of age and older who resided in Delaware Valley (i.e., Delaware, New Jersey, and Pennsylvania). The health belief model (HBM) was used to undergird data analysis, seeking patterns and themes that feed the spread of HIV in this population. NVivo, a computer-assisted qualitative data analysis software program, was used to organize, analyze, sort, classify, and examine information with data modeling.

Background of the Study

According to CDC, (2017) although Blacks now comprise 13% of the total population of the United States accounted for 43% of HIV diagnosis with 42% HIV/AID death rates higher than any other ethnic racial group in the USA. Moreover, in 2010 they accounted for 51% of new HIV diagnoses in the United States (CDC, 2010). The infected proportion of African-born Black men in this group had not been delineated, despite contributing to the HIV epidemic in the United States (Kerani et al., 2008; Amadi, 2012;) Ogunjimi, 2017; Aggravating the situation is that U.S. government surveillance

reports previously did not distinguish between native-born Blacks and African-born residents (CDC, 2008) although the African-born population had increased from 200,000 to 1.5 million as of the 2010 census (McCabe, Randy, & Fix, 2011). African immigrant men tend to contract HIV within 10 years of arrival in the United States, and poverty, lack of social network, loneliness, and cultural ambiguity contribute to African immigrants choosing to take risks alleviating experiences of hardship (Kwakwa et al., 2012).

To survive in their newfound country and provide support for their families, African immigrants tend to take low-paying jobs that most Americans have rejected. These jobs might include working in restaurants and hotels as cleaners or becoming taxicab drivers, limousine drivers, and city parking-garage attendants (Lippman et al., 2013). African immigrant men have been diagnosed later than African immigrant women with HIV, consequently, spreading the disease to various sexual partners before they discover they are infected (Kerani et al., 2008). In addition, African immigrant men who are infected are likely to expose themselves to HIV through sexual encounters due to their mobility, secondary relationships, and risk-taking behaviors (Othieno, 2007). Furthermore, Page, Goldbaum, Kent, and Bushkin (2009) identified that access to regular HIV care is limited for African immigrants and early detection of the disease are hampered by lack of access to health care. Due to a knowledge deficit about disease transmission, a great need persists to assess knowledge about HIV transmission and to design ongoing research on the implications that lead to African immigrants exposing themselves to HIV (Page et al., 2009). Epidemiologic differences exist between native-

and foreign-born Black people diagnosed with HIV infection in 33 U.S. states (Johnson, Hu, & Dean, 2010). Therefore, it is essential to develop culturally relevant and appropriate data that can be used in HIV surveillance and prevention in this population.

In 2013, the HIV incidence rate was six times higher among African-born immigrants in the United States than the general population (Blanas et al., 2013). In addition, epidemiological data surveillance combined native-born Blacks with African-born Blacks (Kerani et al., 2008), rendering the delineation of incidence of HIV difficult to diffuse; however, once data were disentangled, African-born Blacks accounted for a higher incidence rate than native-born Blacks. The prevalence of HIV among foreign-born Blacks in King County, Washington increased by 7.5% in 3 years compared to native-born Blacks, for whom the prevalence remained stable (Kent, 2005). Therefore, each state needs to delineate surveillance data to determine the implications of foreign-born diagnostic rates (Kent, 2005).

Problem Statement

The problem is that the prevalence of HIV among African-born residents in the United States is six times greater than the HIV infection rates in the U.S. general population (Blanas et al., 2013). In addition, the infection rate is two thirds higher than the crude diagnosis rates of Black U.S.-born citizens (Johnson et al., 2010) and 12 times greater than the White U.S.-born population (CDC, 2006; 2008). Among African-born U.S. residents, men and women have higher rates of heterosexual HIV transmission than the U.S. general population but lower rates of drug-use-injection-related transmission. The current qualitative study investigated which factors may predispose first-generation

Sub-Saharan African-born men to risk-taking sexual behaviors that may place them at risk of becoming HIV infected. Evidence suggested by Johnson et al. (2010) and Kerani et al. (2008) found the incidence of HIV in eight municipalities where first-generation African-born U.S. residents resided was significantly higher than the national average, despite comprising only 0.5% of the total U.S. population. Thus, understanding the predisposing risk factors among this population is paramount to comprehending what prevention efforts would help curb the tide of infection among this population.

Purpose of the Study

Numerous studies have considered the relationship between immigrants and contracting HIV. For example, Tulloch et al. (2012) analyzed HIV knowledge among Sub-Saharan Africans and Canadian ethnic groups and found that Canadians had greater knowledge about HIV. Furthermore, Mitha, Yirsalign, Cherner, McCutchan, and Langford (2009) examined the risk perceptions and beliefs of Ethiopian immigrants in the United States and found that the beliefs (including polygamy) of the population increased susceptibility to HIV. In addition, Rosenthal et al. (2003) assessed the HIV/AIDS health-service needs of African immigrants and the causes of HIV among various groups of African immigrants. However, none of these studies analyzed the process of transmission from arrival to infection stage. Because the desire and willingness to have multiple partners can be perceived as a cause of pandemic HIV, the need persists to analyze behavior processes and activities that expose male African immigrants to HIV. Exploring this topic has contributed to filling knowledge gaps and may assist in designing preventive strategies among Sub-Saharan African immigrant men in the United States.

Research Questions

1. What is the perceived susceptibility that predisposes Sub-Saharan male African immigrants to sexual risk-taking behaviors when they come to the United States?
2. What are the perceived cultural safeguards (cultural, social, and economic) that existed in Africa that are absent in the United States and have exposed male African-born U.S. residents to HIV?
3. What does the African immigrant male perceive to be dissonant in U.S. culture that promotes sexual risk-taking behavior? [Cultural dissonance is an uncomfortable sense of discord, disharmony, confusion, or conflict experienced by people in the midst of change in their cultural environment.]

Theoretical Foundation

The HBM proposed by Rosenstock (1974) rests on four constructs: perceived susceptibility, perceived severity, perceived benefits, and perceived barriers. In the current study, this model aided in identifying factors that may predispose Sub-Saharan Africans to become involved in sexual risk-taking behavior. The outcome of this study may provide insight into activities that may discourage the spread of HIV. The use of this model assisted in understanding participants' baseline knowledge of HIV transmission, the severity of the disease process, and the benefit of verbalizing their risk participation in activities that may promote the spread of HIV. Asare, Sharma, Bernard, Rojas-Guyler, and Lihshing (2013) used the HBM to ascertain safer sexual behavior among African immigrants. The researchers found that the application of the HBM assisted in increasing

HIV prevention knowledge and hence, reduced HIV among the sample population. Therefore, this study used the HBM to provide the framework to assist in understanding factors that preclude the spread of HIV through sexual risk-taking behavior.

Conceptual Framework

The conceptual framework selected for the current study was grounded theory. Grounded theory was developed by Glaser and Strauss, two U.S. sociologists, while researching *awareness of dying* (Glaser & Strauss, 1965; 1967; Glaser, Strauss, & Strutzel, 1968; Moore, 2009). In their later two-part awareness of dying study, Fagerhaugh and Strauss (1977) stated that the strategy for pain management was unique and distinct from established norms. Additionally, they generated and established a substantive theory regarding patients' pain management. The researchers concluded that initiating pain management could occur when hospital leaders for each specific service or unit understood the significance of pain and their responsibility to provide proper pain management. Hospital leaders would then need to convert that understanding into a commitment that would bring about necessary changes in written and verbal communications (Fagerhaugh & Strauss, 1977). However, at the time of the Glaser and Strauss (1967) study, the authors discovered that the primacy to generate theory for sociological phenomenon was not an essential aspect of the research. Instead, emphasis was allotted to verification and empirical research. Glaser and Strauss (1967) criticized models of sociological research and stressed the need to generate theory that arose from concepts rather than using theories conceived from empirical assumptions (Glaser &

Strauss, 1967). Nevertheless, Glaser and Strauss (1967) spearheaded a methodology that merged the gap between empirical research and theory and called it grounded theory.

The current study used grounded theory as the conceptual framework for research. Grounded theory begins with a research question, followed by data collection (Glaser & Strauss, 1967). Researchers analyze the data seeking repeating ideas that they label as concepts. Researchers group and tag repeated elements with codes into categories to generate theory (Strauss & Corbin, 1990). Furthermore, various methodological techniques are distinct to grounded theory and collection of data and analysis should be performed simultaneously (Glaser & Strauss, 1978). The procedure should follow a definitive sequence of theoretical sampling, to coding, constant comparison, saturation, and memoranda writing (Glaser & Strauss, 1967). The authors devised the acclaimed techniques to assure that as data is grouped for coding, juxtaposed, and organized into categories that are considerably abstract, they will lead to creating a budding theory. Researchers can annotate and refine this neoteric theory from newly received raw data to produce a reciprocal connection between data and theoretical formation (Strauss & Corbin, 1994). Using this strategy, researchers proliferate abstract concepts that are rigorously validated and grounded in the research itself. Furthermore, Glaser and Strauss (1967) argued that grounded theory propitiously conjoins research and theory as researchers methodically discover a theory in the construct of systematic research.

Grounded theory was selected for this study because it attempted to predict and explain various types of behavior included in the research. This study used interviews for

data collection about risk-taking behavior. Further, actions and factors that expose male Sub-Saharan African-born immigrants in the United States to HIV were explored.

Nature of the Study

Grounded theory was the qualitative approach used to analyze first-generation male Sub-Saharan African immigrant risk-taking behavior. Fourteen participants were solicited from African churches that cater to these groups; African Association such as Nigerian, Liberian, Tanzanian, and Ethiopian associations; and other related African groups that cater and support African-born immigrant diasporas. The criteria for the sampled population included being a male African-born U.S. resident with the country of origin in Sub-Saharan Africa (East, West, Central, and Southern Africa). The sampled population was interviewed using a tape recorder to document their narrative lived experiences using a distinct set of research questions to ascertain their perceived factors that contributed to acquiring the disease among first-generation male African-born U.S. residents. Members of the sampled population were interviewed individually at a location that was mutually agreed upon. The questions posed were the same for each participant, pretested in a pilot study prior to the interviews.

This qualitative study used recorded interviews to obtain data. The data were then imported into NVivo which assisted in identifying, categorizing, and analyzing common themes as well as grouping the unstructured data. NVivo software allowed me to classify, sort, and arrange data to examine the relationships among the data points.

Definitions

African-born U.S. Residents: People who were born in Africa but chose to migrate and become citizens of the United States.

Sub-Saharan Africans: African people who reside in countries located south of the Sahara desert.

Epidemic: Spreading of a diagnosed disease over time to a large population (CDC, 2016).

Pandemic: A diagnosed infectious disease that, over time, spreads to other larger populations, affecting those in other countries (CDC, 2016).

Human Immunodeficiency Virus (HIV): The viruses that cause AIDS by weakening an individual's immune system, making them susceptible to other infectious diseases (CDC, 2016).

Acquired Immunodeficiency Syndrome (AIDS): Symptoms that accrue from being infected by HIV, resulting in decreased clusters of differentiation 4 cells (CD4), glycoproteins found on the surface of immune cells, to less than 200, rendering the individual's immune system unable to fight other infectious diseases that attack the body (CDC, 2016).

NVivo. A qualitative data-analysis computer software package produced by QSR International, used for analyzing qualitative data.

Assumptions

Researchers have used NVivo researcher tool in qualitative grounded studies to organize data and generate patterns of correlation and later these generated similar

concepts they are used to generate theory (e.g., Asare et al., 2013; Egbe, 2015; Jacobson, 2011; Wamoyi, Fenwick, Urassa, Zaba, & Stones, 2010). The HBM used in this study helped in exploring attitudes, knowledge, and beliefs among first-generation male Sub-Saharan African-born immigrants to the United States to understand risk-taking behavioral activities that engender the spread of HIV in their community.

Asare et al. (2013) used the HBM to determine safer sexual behavior among African immigrants; while, Jacobson (2011) used the model to determine interventions to decrease the transmission of HIV. Researchers (e.g., Egbe, 2015; Wamoyi et al., 2010) have used the NVivo research tool as they analyzed concepts, explored themes and patterns, gained insight into relationships, and translated data into evidence to support research findings.

It was clear that study participants were first-generation male Sub-Saharan African-born U.S. immigrants, selected based on their immigration status and naturalization status. This study has abided by principles stipulated by the study objectives. The last assumption is that study findings from this research may be employed in future health-education campaigns to prevent the spread of HIV/AIDS in this population.

Scope and Delimitations

This study focused on risk factors associated with the spread of HIV among first-generation Sub-Saharan African-born men living in the United States; therefore, results cannot be generalized to other racial groups. In this study, participants were a convenience sample of Sub-Saharan African males who resided in Delaware Valley. As a

result, study outcomes are distinct and succinct and cannot be representative of a larger population as a more substantial sample would be needed to generalize outcomes. The study employed the conceptual framework of grounded theory and the data obtained was based on participants' reflections of their lived experiences. Data was not accrued from observation.

Limitations

English proficiency among study participants is one of the limiting factors. Most Sub-Saharan African immigrants come to the United States due to civil war or conflict in their country of origin. Most come to the United States as adults and consequently, survival is a higher priority than going to school; thus, they have minimal education (Mason, 2016; Rivers, 2012). To avoid English proficiency as a hindrance to participation, participants who can understand and speak English were selected for the study. Another limitation of this study is the longitudinal effect. Because the study took place in less than a year, study findings may need to be replicated to be reliable and generalized to a larger population. Furthermore, because the study participants were all men 20 years of age and older, study findings may be limited because participants responses may not represent children, young adults, or females.

Significance of the Study

Significance to Study and Practice

While investigating health care accessibility and utilization in the District of Columbia Washington D.C., Boundaoni (2015) concluded that health education is the key to improving health care access among African-born immigrants. Therefore, the

knowledge gained from the results of this study have the potential to influence prevention strategies in counseling new African immigrants upon arrival. Educators can integrate and tailor education for African immigrants into the fabric of introducing them to living in the United States. Community social groups, youth organizations, and religious and educational platforms could disseminate the information gained through this study. For mass production and dissemination, educators could create videos to relay the information.

Significance to Theory

This study is significant to theory because it works to answer a gap in the theoretical literature. No prior study has used grounded theory to examine the HIV risk-taking behavior and factors that exposed first-generation Sub-Saharan African-born U.S. immigrant men, 20 years of age and older to HIV/AIDS. Aligned with Glaser and Strauss's (1967) grounded theory, this study has contributed to theory markedly by generating a new inductive approach through the conceptualization of data sampling, coding, constant comparison, saturation, and systematic analysis of grouped categories of data. In addition, researchers can use the incipient theory to produce abstract categories that can be refined and edited by adding newly collected raw data from unsaturated interviews. This refinement can contribute knowledge to the construction of new theories, aligned with the ideas of Strauss and Corbin (1990). Furthermore, the incipient theory from this study reveals contemporary scientific knowledge that has not existed prior to this research. The generated constructs and typologies from male Sub-Saharan African-

born U.S. immigrant participants may aid grounded theory researchers from various disciplines to build their logic and power on a strong inductive and empirical foundation.

Implications for Social Change

The significance of this study is that it has identified some risk factors that may predispose first-generation male Sub-Saharan African-born immigrants, residing in the United States, to becoming HIV-infected. This qualitative study has disclosed the perceptions of Sub-Saharan African immigrant men regarding sexual behavior choices. Kwakwa et al. (2012) noted that the withdrawal of cultural constraints that tend to encourage positive sexual behavioral choices while living in Africa produce a barrier-free environment that predisposes residents to HIV. The subjective data may yield social, spiritual, economic, and psychological themes that predispose Sub-Saharan African male immigrants to risk-taking behavior.

Summary and Transition

Chapter 1 presented the problem statement, purpose of the study, research questions, theoretical foundation, conceptual framework, limitations, and significance of risk-taking behavior in Sub-Saharan African-born immigrants to the United States. This study used a homogenous convenience sample of 14 male Sub-Saharan African-born immigrants to the United States to understand the phenomenon of the risk-taking behaviors that preclude the spread of HIV. Chapter 2 provides detailed information on the literature review, theoretical foundation, and conceptual framework relevant to the risk factors of HIV among this population.

Chapter 2: Literature Review

Literature Search Strategy

To provide a robust literature review for this investigation, the following databases provided information: Google Scholar, PubMed, Cochrane database and Advanced Research database, Sage, EBSCO*host*, CINAHL, Medline, CDC, and the Database of Abstracts of Review of Effect. The Cochrane database provided peer-reviewed articles for validity and research credibility. Definitive search terms and keywords included: *grounded theory*, *HIV risk behavior*, *Sub-Saharan African-born Americans*, *Sub-Saharan Africa*, *African-born U.S. residents*, *HIV epidemic*, *risk factors among Africans in America*, and *HIV among African immigrants in the United States*. The related literature and journals provided an iterative protocol to ensure validity and relevance.

In the United States, Blacks suffer disproportionately with a high incidence of HIV/AIDS (Blanas et al., 2013; Koku et al., 2016). Currently, in the United States, Black migrants account for the highest prevalence of HIV/AIDS (Crawford, Caldwell, & Bush, 2012; Kent, 2005; Kerani et al., 2008) creating a need to examine the processes causing the increase and the prevalence of HIV within this community. Sub-Saharan Africa has been reckoned as the epidemic epicenters of HIV/AIDS according to the Joint United Nations Program on HIV/AIDS (UNAIDS, 2014). Previously, only a few limited studies had analyzed HIV among Sub-Saharan African-born migrants in the United States (e.g., Harawa, Bingham, Cochran, Greenland, & Cunningham, 2002). Currently, corroborative studies from the

United Kingdom (Doyal, 2009; Health Protection Agency, 2008), Canada (Remis, 2003), European countries (EuroHIV, 2005; Sinka, Mortimer, & Evans, 2003), and Australia (Korner, 2007; Lemoh, Biggs, & Hellard, 2008) provide shocking glimpses into the intense increases in the rates of HIV prevalence among the African-born immigrant community. Other research findings such as Kerani et al. (2008) labeled the scope of HIV outbreak among U.S. African-born immigrant as a *hidden epidemic* and noted that the epidemic has been taken too lightly due to a surveillance report often grouped together with US-born African Americans (Kerani et al., 2008).

Theoretical Foundation

Health Belief Model

The theoretical foundation used in this study is HBM. First designed in the 1950s, this model helps detect why individuals who had access to preventive medical care were reluctant to partake. The HBM was hypothesized by Rosenstock (1966) and later expanded by Janz and Becker (1984), Rosenstock, Strecher, and Becker (1988), and Schiavo (2007). Public health and social science researchers have used the HBM. Creswell (2009) defined the HBM as interconnected constructs that could be used to explain propositions that represent experiences that explain natural phenomena. Furthermore, Creswell (2005) suggested that one strength of using the HBM in qualitative methodology is its synthesis of research without using predetermined hypotheses.

The proposition of the HBM is that perceptions of the risk of health-related problems inspire individual health choices. An individual's perception of the seriousness of their condition will drive their desire to take action to prevent the disease (Johnson, Mues, Mayne, & Kiblawi, 2008). Aligned with Schiavo (2007), the six constructs of the HBM were ideal for this qualitative study because I have analyzed (a) HIV risk perception among participants before they acquired the disease, (b) knowledge and attitudes toward HIV, and (c) participants' sexual health beliefs. This study used the six components of the HBM: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy (Schiavo, 2007).

Conceptual Framework

This study used grounded theory as the conceptual framework for research. The theory indicates that grounded theory is "the discovery of theory from data systematically obtained from social research" (Glaser & Strauss, 1967, p. 2). Grounded theory begins with a research question, then data collection, followed by analysis of the data while seeking repeated ideas or concepts (Glaser & Strauss, 1967). Strauss and Corbin (1990) suggested researchers group and tag repeated elements with codes into categories to generate theory. Furthermore, Glaser and Strauss (1967) designed various methodological techniques distinct to grounded theory and specified that collection of data and analysis should materialize simultaneously. Lastly, researchers should follow a definitive sequence of theoretical sampling, coding, constant comparison, saturation, and memoranda writing. The acclaimed techniques assured that as data are grouped, coded, juxtaposed, and organized into categories, they form the abstract of a budding theory.

Researchers can annotate and refine this neoteric theory with new raw data to produce a reciprocal connection between data and theoretical formation (Strauss & Corbin, 1994). This strategy warrants that researchers rigorously validate and ground abstract concepts in the research itself. Furthermore, grounded conjoins research and theory as it methodically reveals a theory in the construct of the systematic research (Glaser & Strauss, 1967). Grounded theory was selected for this study because it helps researchers predict and explain various types of behavior included in the research. For this study, I used interviews for data collection about risk-taking behavior, actions, and factors that may expose Sub-Saharan African-born U.S. men to HIV.

Literature Review

History

In 1981, when a group of young homosexual men showed symptoms of rare malignancies and opportunistic infections, healthcare researchers first identified acquired immune deficiency (AIDS) as a disease (CDC, 1981; Greene, 2007). The virus, originally identified as a retrovirus, encouraged researchers who used the name human immune-deficiency virus (HIV) (Barre-Sinoussi et al., 1983; Popovic, Sarngadharan, Read, & Gallo, 1984). The disease spreads by sexual intercourse, needle sharing, and perinatal routes (Cohen et al., 2011) and 80% of adults who acquired HIV after exposure through mucosal surfaces also contracted AIDS (Hladik & McElrath, 2008). In June 1981, the CDC (1981) found early noticeable symptoms of HIV infection, describing the symptom of pneumocystis carinii, candida mucosal infection, fever, and cytomegalovirus in five young gay men in Los Angeles (Masur et al., 1981). The case report indicated that all

five died after their condition deteriorated, despite aggressive treatment with antibiotics. Simultaneously, a rare case of infection of Kaposi's sarcoma, a form of cancer, infected 41 gay men in New York and California. By the end of 1981, of 270 reported incidents of HIV, 121 people had died (Hymes et al., 1981). The symptoms of swollen lymph nodes, rash, lagging energy, tiring easily, reduced appetite, fever, and headaches were reported frequently in the county and city of San Francisco by 1982.

The CDC (1982) approximated that 10,000 people could be infected with the disease, labeled gay-related immune-deficient syndrome. European countries started reporting AIDS cases. Uganda, an African country, reported increased numbers of a new fatal wasting disease. Congressional representatives in the United States labeled it a gay men's health crisis and allocated $10 million to open clinics and crisis centers to attend to an epidemic (CDC, 1982). The National Institutes of Health suggested that a retrovirus caused AIDS. Meanwhile, the CDC started reporting cases of AIDS in female sexual partners of men with AIDS.

The CDC (1983) dismissed transmission through skin contact, water, food, and air. The CDC recommended a conference to ascertain blood-bank policies for testing blood for HIV (Berre-Sinoussi, 1983; CDC, 1983). The National Cancer Institute revealed they had found the cause of AIDS, the retrovirus HTLV-111 (Marx, 1984). At the recommendation of CDC, bathhouses and private sex clubs closed as a result of high-risk sexual activity in San Francisco, New York, and Los Angeles (AIDS.gov, 1984).

The CDC (1984) announced the public should avoid reusing needles or sharing needles to inject drugs. Towards the end of 1984, the CDC announced that of 7,699

cases, 3,665 AIDS deaths occurred in the United States with 762 new cases disclosed in Europe (Reilly, 2009). In 1985 the U.S. Department of Health and Human Services and WHO held the first joint AIDS conference (AIDS.gov, 1985). The U.S. Food and Drug Administration (FDA) licensed and introduced the initial ELISA commercial blood test (AIDS.gov, 1985). In Europe, The Netherlands announced a program for syringe and needle exchange, due to growing concern of AIDS transmission (National Institute on Drug Abuse, 1988). By the end of 1985, every country in the world had reported at least some cases of AIDS with a total of 20,303 cases (AIDS.gov, 1985).

In 1986, the International Committee on the Taxonomy of Viruses announced that the international name for the virus that caused AIDS was to be called HIV rather than HTLV-III/LAV (Case, 1986). At the end of 1986, about 85 countries had announced 38,401 cases of AIDS to WHO. The regional distribution of HIV was Asia, 84; Africa, 2,323; the Americas, 31,741; Europe, 3,858; and the Caribbean, 395 (Bureau of Hygiene and Tropical Diseases, 1986). By February 1987, due to the rapidly accelerating HIV epidemic, the WHO implemented a global program on AIDS to promote awareness, propagate evidence-based policies, promote international nongovernmental organizations, contribute technical and monetary support to countries, conduct research, and support the rights of people living with HIV disease (CDC, 2012).

By the middle of 1987, the FDA had approved the first antiretroviral drug, Zidovudine (AZT), as the paramount treatment for HIV (AIDSinfo, 1987). Additionally, Western blot blood-test kits provided a specific HIV antibody test (Kaiser Foundation, 2014). In the same period of 1987, WHO scientists confirmed that HIV could be

transmitted from mother to child during breastfeeding. By December 1987, WHO indicated that 71,751 cases of AIDS had been reported, of which 47,022 cases emerged from the United States. WHO further predicted that between 5 to 10 million people had been infected and were living with HIV globally (CDC, 2012).

In 1988, WHO declared every December 1st to be World AIDS Day (Worlds AIDS Day.org, 1988) in the United States, and established a nationwide HIV/AIDS care system, supported by the Ryan White Comprehensive AIDS Resources Emergency Act (AIDS.gov, 1987). By March 1989, WHO estimated 400,000 cases of HIV through 145 countries and 142,000 AIDS cases. Meanwhile, the number of HIV cases in the United States had increased to 100,000. In June 1990, during the 6th International AIDS Conference in San Francisco, individuals protested against the U.S. immigration policy that stopped HIV-infected people from entering the country. As a result, nongovernmental organizations refused to attend the international conference (Orkin, 1990). By July 1990, the U.S. Congress had passed the American with Disabilities Act (ADA), which prohibits discrimination against people with disabilities and included people living with HIV (AIDS.gov, 1990). During the same year, the FDA approved the use of AZT to treat children with AIDS (Oncology, 1990). By the end of the year, globally, 307,000 AIDS cases and 8 to 10 million people were living with HIV.

In 1991, the Artists Caucus launched the Red Ribbon Project to create a symbol of compassion for people living with HIV and people who care for them. In the same period, Earvin “Magic” Johnson contracted the disease, announced his retirement from the sport, and started educating young people about HIV/AIDS. During 1992, tennis star

Arthur Ashe revealed that a blood transfusion he had received caused the HIV infection (AIDS.gov, 1993; *New York Times,* 1992). The United States voted, compellingly, to retain the ban against people with HIV entering the country. The CDC added pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer to indicators of AIDS. By the end of 1993, WHO reported 2.5 million AIDS cases worldwide with 700,000 people living with HIV in Asia alone.

The CDC (1994) recommended that AZT is used to prevent HIV mother-to-child transmission. In addition, the FDA approved the first oral HIV test, the nonblood HIV test. In June 1995, the FDA announced approval of the first protease inhibitor, a very active HIV antiretroviral therapy (James, 1995); however, by the end of 1995, WHO announced 4.7 million new HIV infections worldwide with Southeast Asia reporting 2.5 million and 1.9 million in Sub-Saharan Africa (Mann, 1990).

By 1996, the United Nations Joint Commission on AIDS formed as UNAIDS to champion advocacy for worldwide actions against the epidemic and coordinating HIV/AIDS efforts across the United Nations (UNAIDS, 2008). Furthermore, the 11th International AIDS Conference in Vancouver highlighted optimism against AIDS after announcing the effectiveness of HIV antiretroviral therapy and reduction in AIDS-related deaths (*Los Angeles Times,* 1996). Toward the end of 1996, the FDA announced the first home testing kit that would measure a viral load, the level of HIV in the blood. The FDA also approved the nonnucleoside transcriptase inhibitor drug (nevirapine) and the first HIV urine test. By the end of 1996, new HIV infections were identified in Eastern

Europe, the former Soviet Union, Vietnam, Cambodia, and China with the new global HIV rate at 23 million people living with the disease.

In 1997, the FDA validated COMBIVIR®, a drug that combined two antiretroviral drugs, easing self-administration for people with HIV. Between 1997 and 1998, UNAIDS announced an estimated 30 million people with HIV and with a rate of 16,000 new infections a day (Washington Post, 1997). In 1999, WHO disclosed that HIV/AIDS was the fourth largest cause of death globally and the top infectious killer on the continent of Africa. By the end of 1999, the disease had infected an estimated 33 million people who were living with the disease and 14 million died from AIDS since the inception of the epidemic (WHO, 1999).

In July of 2000, UNAIDS started negotiating with pharmaceutical companies to decrease the price of antiretroviral drug prices for developing nations. Before the end of 2000, the United Nations adopted Millennium Development Goals, which encompassed special goals to regress the spread of HIV/AIDS, tuberculosis, and malaria (United Nations, 2000). In 2001, the United Nations announced the conception of a Global Fund that developing countries and organizations could use to combat the spread of HIV through prevention, treatment, and purchase of medication. In addition, drug manufacturers generally consented to make discounted, generic forms of HIV/AIDS drugs for developing countries (United Nations, 2000).

In November of 2001, the World Trade Organization agreed to the Doha Declaration that permitted developing countries to produce generic medications to fight HIV/AIDS epidemics (HIVPolicy.org, 2001; World Trade Organization, 2001). In 2002,

the FDA approved the first rapid HIV test kit with 99.9% accuracy. In April 2002, UNAIDS reported that HIV/AIDS in Sub-Saharan Africa was now the leading cause of death. In 2003, President George W. Bush initiated the creation of the U.S. President's Emergency Plan for AIDS Relief, a $15 billion 5-year plan to fight AIDS, especially in poor nations with increased rates of HIV infection (Office of the Global AIDS Coordinator, U.S. Department of State, 2004).

From 2004 to 2005, WHO initiated the "*3 by 5"* program to bring HIV treatment to more than 3 million HIV infected people worldwide (WHO, 2003). In 2006, researchers discovered that male circumcision decreased the risk of male to female HIV transmission, with up to a 60% prevention rate (Auvert et al., 2005). From 2007 to 2009, WHO and UNAIDS provided new guidelines recommending provider-initiated HIV testing in health care settings to increase understanding of HIV status and potentially widen opportunities for access to HIV prevention and treatment (WHO, 2007).

In 2010, the U.S. government removed the travel ban inhibiting HIV-positive people from entering the United States. In July, the CDC hailed the Centre for the AIDS Program of Research in South Africa microbicide trial a success after results indicated that the gel reduces the risk of HIV infection in women by 40%. Furthermore, results from pre-exposure prophylaxis initiative trial showed a 40% decrease in infection rates among men who have sex with men who used preexposure prophylaxis (Grand, 2010; Karim, Karim, Frohlich, & Grobler, 2010; *New York Times*, 2009). In 2011, the outcome of an HIV Prevention Trials Network trial indicated that early results of antiretroviral treatment decreased the risk of HIV transmission by 96% among couples who were

sero-discordant (i.e., one partner is HIV negative and the other is HIV positive). In addition, in August of 2010, the FDA approved COMPLERA®, a combined fixed-dose bolstering treatment option presented to people infected with HIV (Cohen et al., 2011).

In 2012, the FDA authorized pre-exposure prophylaxis for HIV-negative people to inhibit the sexual transmission of HIV and 54% of the population became eligible to prevent the spread of HIV from sexual partners who did not have HIV (FDA, 2012). In 2013, UNAIDS announced that AIDS-related deaths had diminished by 30%; however, an estimated 35 million people were still living with HIV (UNAIDS, 2013). In 2014, UNAIDS announced a *Fast Track* program and called for increased operations of HIV prevention and treatment programs to prevent 28 million new infections and eliminate the epidemic as a public health problem by 2030. Furthermore, UNAIDS (2014) launched the *90–90–90* program, which aimed to diagnosed people who were living with HIV but did not know they had been infected, to have 90% of the infected population able to access antiviral treatment, and to bring about 90% viral suppression in the infected HIV population.

In 2015, UNAIDS declared that the Millennium Development Goal for HIV and AIDS had been achieved 6 months ahead of schedule. The goal objective of inhibiting and reversing the spread of HIV impacted 15 million people who received treatment. In September 2015, WHO announced new guidelines for HIV treatment. More specifically, they declared that people living with HIV must receive antiretroviral treatment despite their CD4 count and as soon as possible following diagnosis. In October 2015, UNAIDS announced their 2016–2021 prevention and treatment strategy in new sustainable

initiative targets that required an increased rapid response to global HIV prevention, achieving zero discrimination, and a treatment target of 90% of the infected HIV population (WHO, 2015; UNAIDS, 2015)

HIV/AIDS and Immigration

According to the American Community Survey, between 2008 and 2012, 39.8 million foreign-born people lived in the United States, which included 1.6 million from Africa or a total of 4% of the foreign-born population (U.S. Census Bureau, 2014). Beginning in 1987, travelers and foreign-born persons diagnosed with HIV were forbidden from entering or from settling in the United States without special legal judgments. In 2008, the U.S. Congress withdrew HIV from a series of diseases of public health relevance, which necessitated President Barack Obama abolishing the travel ban in January 2010. Because the ban was removed, HIV no longer prevents infected immigrants from entering the United States; as a result, the United States anticipated an increased number of immigrants infected with HIV (Page et al., 2009).

Migration is a well-recognized risk factor for HIV infection (Tompkins, Smith, Jones, & Swindells, 2006). The perplexity of a new environment can result in unsafe sexual behaviors, substance abuse, and mental health illnesses that increase the risk of acquiring HIV. In contrast to other populations, the study of immigrants infected with HIV in the United States has been fragmented across various disciplines over the past 25 years. An accurate description of the HIV epidemic in foreign-born people in the United States is still unavailable (Page et al., 2009). Only a few reports documented the clinical and epidemiological characteristics of immigrants and refugees infected with HIV in

selected areas. Similarly, reports have only partly described some deficiencies in HIV/AIDS knowledge, testing, and access to care in these groups. Most reports, however, have failed to distinguish between foreign-born immigrants and U.S.-born minorities and have not recognized differences in immigrant populations by country of origin. These limitations have reduced the effect of risk-reduction and healthcare-access strategies in these groups (Page et al., 2009).

To untangle this problem, Page et al. (2009) suggested developing a National HIV in Foreign-born Registry (NHFR) that can serve as an essential solution to this problem. NHFR can house a multicenter, network-based analysis program designed to gather information on immigrants who have contracted HIV and are receiving medical care in the United States. The goal of NHFR is to augment understanding and identify imperfections in the preventative healthcare system and identify prospective needs in foreign-born people infected with HIV. The termination of the HIV access ban was the first stage forward to developing comprehensive immigration reform, and the NHFR can be a prerequisite for the effective assistance and improved care of the migrant population.

In a study among African-born U.S. residents, Blanas et al. (2013) discovered that HIV diagnostic rates were six times higher than the general U.S. population. African-born U.S. residents had late diagnosis but decreased mortality rates from HIV. African-born U.S. women had higher rates of HIV, high heterosexual transmission, and decreased injectable drug-use transmission compared to the general population. The researchers criticized surveillance reports that usually combined African-born U.S. residents with African American Blacks. Increased rates of HIV among African-born residents coupled

with increasing immigration and lack of proficient surveillance data, underscored the necessity for distinct epidemiologic data on foreign-born immigrants that could assist in delineating HIV-epidemic trends and identify pertinent healthcare services (Blanas et al., 2013).

The pattern of the predicament of African-born migrants does not only apply to the United States but other Western countries that have documented high rates of HIV in this same population. In New Zealand, for example, despite comprising less than 0.4% of the total New Zealand population, 19% of the 2,643 people diagnosed with HIV are African immigrants (Birukila, Brunton, & Dickson, 2013). Furthermore, among heterosexuals diagnosed with HIV in New Zealand, 96% of the men and 91% of the women are African immigrants. In the Birukila et al. (2013) study, evidence substantiated that, of the infected HIV African immigrants in New Zealand, some were infected while living in Africa and others while residing in New Zealand. Due to increased HIV rates among New Zealand African-born residents, researchers advocated the need to establish preventive HIV methods that target African Blacks in New Zealand.

African-born U.S. residents have high risk of HIV/AIDS due to their risky sexual behavior (Asare et al., 2013). Asare et al. (2013) examined safe sexual behavior among African immigrants and used HBM in the cross-sectional design to analyze safe sexual behaviors among African immigrants and use of condoms. The researchers found that perceived susceptibility had a strong correlation with participants using condoms. Study participants who believed they were more susceptible to contracting HIV due to their present and past sexual behaviors, tended to use condoms during sexual encounters. In

contrast, respondents who had no connotation of susceptibility tended not to use condoms during sexual relationships, resulting in an increased rate of transmission. Various researchers also reported susceptibility as a compelling predictor of condom use (Adith & Alexander, 1999; Sutherland & Curtis 2004; Tenkoran, Rajulton, & Maticka, 2009).

In a study to evaluate differences in CD4 cell counts based on gender, Kwakwa et al. (2012) compared African immigrants diagnosed with HIV with a non-African, foreign-born cohort in the city of Philadelphia. The researchers found that African-born men in Philadelphia were diagnosed with HIV at a later stage of the disease compared to African women. Women gained early diagnosis of HIV due to routine reproductive health examinations. The authors concluded that African-born men should engage in routine HIV testing to detect the disease early and promote early treatment.

Early diagnosis of HIV and access to care are essential and empowering to the infected individual to avoid sexual risk-taking behavior and prevent the spread of the disease in the population. Eteni and Wood (2011) found that delayed diagnosis was also a problem in their study, examining African-born immigrants in King County, Washington. The researchers found that African-born U.S. residents presented with AIDS with a late diagnosis compared to U.S.-born residents who sought medical care earlier and were diagnosed with HIV (Eteni & Wood, 2011). Other studies analyzed gender as the basis for late diagnosis (Gay, Napravnik, & Eron, 2006). Mugavera, Castellano, Edelman, and Hicks (2007) examined late diagnosis of HIV infection in relation to age and sex. Yang et al. (2010) analyzed late diagnosis in Houston/Harris County, Texas. Prosser, Tang, and Hall (2010) examined HIV in individuals born outside the United States from 2007 to

2010. Prosser et al. (2010) found that after examining data from 46 states and five U.S. territories, foreign-born individuals had higher percentages of HIV infection through heterosexual relationships, which stood at 39.4%; whereas U.S.-born people had 27.2%. In the Prosser et al. study, foreign-born men had a later diagnosis of HIV than their U.S.-born counterparts and men had later HIV diagnoses compared to women. Similarly, in Uganda, men sought care for the disease later than women (Kigozi et al., 2009).

Despite advancements in HIV disease management, the rate of HIV among African-born immigrants has not diminished. In the UK, Sub-Saharan Africans comprise 1.8% of the entire population and have the highest rates of HIV in the UK. For example, in 2012 they comprised 34% of all those infected with HIV. Burns, Fakoya, Copas, and French (2001) found that regardless of the statistics in the UK, Black African communities have a lower percentage of the population and still suffer from late diagnosis. The need is urgent to address the delay in care, to maximize clinical outcomes, and to decrease the spread of disease among the Black African population (Burns et al., 2001).

Other studies examined HIV knowledge as the principle premise that leads to optimized safe sex with condom use, intention, abstinence, treatment, and testing. In a Canadian study, Tulloch et al. (2012) compared Canadian-born and Sub-Saharan African-born individuals living with HIV in Canada. The authors deduced that Canadian-born individuals living with HIV scored higher in HIV knowledge than Sub-Saharan HIV patients. Lack of knowledge could be the catalyst for high rates of HIV among Sub-Saharan African people. Tulloch et al. (2012) recommended ongoing HIV education

reinforcement among Sub-Saharan Africans in addition to targeted culture-specific education to address significant knowledge gaps among the Black African population.

Studies that analyzed HIV knowledge and safe-sex included Bazargan, Kelly, Stein, Husaini, and Bazargan (2000), who examined "Correlates of HIV Risk-Taking Characteristics in African-American College Students"; Schroder and Carey (2005) who analyzed "Anger as Moderator of Safer Sex Motivation Among Low-Income Urban Women"; Braithwaite and Thomas (2001), who evaluated "HIV/AIDS Knowledge, Attitudes, and Risk Behaviors Among African-American and Caribbean College Women"; and Petros-Nustas, Kulwicki, and Zumout (2002) examined "Student's Knowledge, Attitudes, and Beliefs and AIDS." These studies indicated a stronger relationship must exist between HIV reduction and knowledge acquisition to prevent the spread of disease in the community.

Family Values of African Americans

According to Brown (2013), African American values have been influenced by greater origins from African diaspora. Prior to the abolition of slavery, African American families separated children and parents, were taken to different geographical regions, and were sold to different merchants. The blood relative separation created a new dimension of family which gave them a new attitude and unique emotional bonds. Disjointing with blood relatives encouraged the practice of designating close racially related loved ones and friends such as aunts, nieces, and nephews, even though not related by bloodline; this cultural behavior has roots in Africa (Davies, 2008; Okpewho & Nzegwu, 2009). Moreover, to be given such family title was carefully measured, reckoned as honor with

greater admiration and responsibility (Olliz-Boyd, 2010). The tradition of respecting elders with the highest dignity despite not being family was also another custom from the origins of African culture based on the fact that elderly individuals had suffered indignation and hard life from which younglings can draw wisdom and knowledge judiciously (Carter, 2010; Hine, Danielle, & Trica, 2009).

Transformation to Freedom

During emancipation, a period when slavery came to an end, freed slaves found a sense of self-determination traveling through the northern states with sense free will and autonomy (Brown, 2013). A lot of freed slaves started looking for opportunities to rebuild their family traditional structures. To maintain and gain equal footing with the rest of white communities, some African Americans ventured into establishing businesses. Others sought out academic institutions where they desired to acquire degrees to become nurses, lawyers, doctors, teachers, and related professions to redeem themselves with the means of survival and become respectable figures of the society (Davies, 2008; Hine et al., 2009). The determination to survive as American people, African Americans needed civil rights, which because American pro-slavery laws had created impediments for their involvement in governance and being members of electorate. To transform troubles of civil liberty, African American were thrust into a decade fight which ended up with a lot of black people being killed including Martin Luther King Jr. (Arthur, 2008; Brown, 2013; Wisdom & Puplampu, 2005). After the success of the civil rights movements, the persistence and tenacity paid off with the right to elect officials who represented their people and social progressive needs creating

incredible potency and strength of African American family values (Brown, 2013; Curry, Duke, Eric, & Smith, 2009).

Effect of Religion

Redding (1993) identified that religion was the catalyst that brought the African Americans together during slavery or the civil liberty movement. Through communal worship, African Americans discovered unity, strength, and motivation to move forward and forgiveness for their oppressor despite the cruelty and injustice (Farrah, 2009). Utilizing religious values, African Americans instilled family values in their children including honesty, treating humans with dignity and integrity, and compassion for the poor. These family values are still being instilled in African American children today (Thompson & McRae, 2001). Even though some African Americans married publicly, sex before marriage between male and female was the norm (Barrie, 2012; Nesby, 2013).

Family Unity and Evolution African Americans

The African American family has radically evolved in the past 30 years with statistics showing lower marriage rates, high separation rates, and higher divorce rates with a greater number of children raised by single mother (Cozart, 2016; Koball, 1998; Woodroffe, 2011). Koball (1998) found that among African American males conditions are severely muddled by high crime rates, decreased academic achievement, unemployment, gravitation for high rates of homosexuality, and high rates of HIV infections (Hampton et al., 2013; Smith, 2006). The social mischievousness among male African American has created a family structure disarray and crisis among African American families (Sherouse, 2013). Nevertheless, after emancipation and the civil rights

movement, African American families flourished with strong family establishment (Coleman, 2016; Day, 2013; Jones, 2006). At this time, families are found to be multi-generational, sharing the same home and the family values of respecting elders, no back talk, to practice good morals are instilled in the younger generations. With the struggle for survival, gender roles got distorted as the family strived to work together to combine housekeeping, work schedule, and schooling to improve their standard of living (Jones, 2006; Kim, 2002). As the African American freedom improved, likewise family relationships also were strengthened as the social structure of parents, grandparents, in-laws, and children depended on each other for psychological, emotional, and financial support during good and difficult times (Young, 2016).

African American in Twentieth Century

During the 20th century, especially the 1960s onwards, the African American social structure started to change. Family statistics projected that approximately 80% of African American families during this 1960s were headed by a husband and wife (Darr, 2009; Jones, 2006). However, as economic conditions improved in certain city areas women were more likely to find a job than men (Brown, 2013). After the 1960s, as economic conditions improved, African American women became more educated and worked more outside homes than men – creating change in the family dynamics and headship (Harris, 2002). This transformation in women's economic status resulted in African American women becoming the head of the household.

Transformation in the African American Family

By the late 20th century, cultural values and social trends started evolving and diverting into various belief ethos and sophistication of African American cultural values became unhinged. African American started to participate in all socioeconomic level relative to other ethnic groups. Some got involved in arts, music, education, owning businesses and companies (Allen, 2016; Brown, 2013; Danielson, 2015). Family relationships have also changed, increased single parenting and most children born without a father figurehead (Ivory, 2010; Mabian, 1996). Sexual orientation evolved from the focus of heterosexual relationships to homosexuality, bisexual, and other various types of family relationships (Shegog, 2008; Sherouse, 2013).

African American and HIV

In 2016, even though they only accounted for 12% of the U.S. population, African Americans accounted for 44% of all HIV diagnosis (CDC, 2017). Furthermore, African Americans comprise the highest quantity of new HIV diagnosis and those living with AIDS diagnosis (CDC, 2017). Due to transformation in sexual orientation among African Americans, this currently includes higher rates of homosexuality and bisexual. Consequently, in 2016 about 17,528 African Americans were diagnosed with HIV. This included 12,890 men and 4,560 women. Of these, 58% (or 10,223) were homosexual and bisexual men (CDC, 2017). Smith (2006) conducted a study to examine why African American men engaged in hidden sexual activities with other men. The study found that some men are involved in these activities because they want to be accepted within social groups. For example, if they found themselves in gay groups they are willing to go the

extra mile and expose themselves to this behavior even if they are not homosexuals. Other reasons indicated in the study was because of curiosity, homophobia, stigma, religion, and African American male masculinity. Kennedy (2007) conducted a study to deduce why African American males are more susceptible to contracting HIV. The study found extensive behavior of unprotected sex, sexual activity during incarceration, lack of education about the understanding of the spread of HIV, and covert sexual identity.

First-generation African-born U.S. Residents

The number of African-born immigrants arriving in the United States from African countries continues to increase. Current statistics indicate that the African population has doubled since 1970 to roughly 2.1 million African immigrants. The surge of African immigrants affords to explain also the effect on the increasing rates of HIV (Elo, Frankenberg, Gansey, & Thomas, 2015; Moore, 2000; Porter, 2011). Previously, African immigrants primarily came to the United States from Morocco, South Africa, and Egypt this accounted for 60% of migrants from Africa. Currently, the variety of African nationals coming to the United States has changed to include Sub-Saharan African countries such as Nigeria, Kenya, Ethiopia/Eritrea, Ghana, Liberia, Zimbabwe, Tanzania, Uganda, Somalia, and other related countries. The immigrants from these countries have continued to increase and are expected to grow due to visa prospects in the United States (Frankenberg, Gansey, & Thomas, 2015). From 2008 to 2011, the American community survey indicated three primary visa types were used which included employment-based (which includes diversity visas), refugee-based, and lottery program visas. The arrival of Sub-Saharan Africans in the United States has furthered ethnic and racial mix dynamics

of the African population causing interest for policy planners and issues of assimilation (Creek, 2015; Djamba, 1999; Mebuin, 2017; Porter, 2011). Various studies have analyzed the acculturative experience of African immigrant residents upon arrival while other studies have analyzed international student experiences in the United States (Ineson et al. 2006, Mossakowski, 2003, Poyrazli & Lopez, 2007; Ready, 2012; Wong & Halgin, 2006). Just like Sub-Saharan Africa immigrants, most African international students who follow their academic dreams in the United States experience nerve-racking acculturative experiences that may include a sense of isolation, confusion, alienation, discrimination, and language impediments (Mori 2000; Nebedum-Ezeh 1997; Poyrazli & Lopez 2007; Puritt 1978). During the period of adjusting to life in the United States, Black Africans may experience fatigue, depression, and homesickness (Adelegan & Parks 1985; Asrabadi, 1994).

Sub-Saharan African Culture

Sub-Saharan Africa consists of a variety of countries with a mixture of cultures and tribes. Currently, among African countries, in addition to democratic governing institution, each tribe has a king leadership and specific tribal chief leaders who extend the kings rule over the tribe. Languages are uniquely accentuated based on each tribe and as a result, each country can have different and various tribal languages and unique cultural practices differing from other tribes within the same country (Abraham, 2001).

Even though African culture may be distinct from tribe to tribe and from country to country, there are similarities when closely studied. Some examples include the morals they uphold, the passion and admiration for respecting their culture and diversity, respect

for aged and elderly, respect for kings and chiefs who are leaders in the community, music, dancing, and artistry in painting and wooden artifacts. The African culture may be distinct for a specific region of the continent. For example, female genital mutilation is specific to northwest African countries such as Benin, Egypt, Chad, Central African Republic, Burkina Faso, Djibouti, and Cote-d'Ivoire (Bosch, 2007; Gele, Bo, & Sundby, 2013; Kolawole, 2011; Marinsek, 2007; Sauer & Neubauer, 2014). Male circumcision is very common among Islam dominated practicing tribes and countries (Morris et al., 2012; Wilcken, Keil, & Dick, 2010).

Currently, Sub-Sahara's main languages can be divided into various sections such as the ethnolinguistic divisions covering the countries of the northern region which are part of the Horn of Africa; Niger to Congo involve speakers from the Bantu division for most of Sub-Saharan African. Nilo-Saharan languages accentuation covers parts of Sahara and Sahel including parts of Eastern Africa and Southern Africa (Omamegbe, 2010). After many African countries where colonized by western countries, the indigenous languages remained intact but colonizing masters left their imprint of western languages on those African countries (Schapendonk, 2012). After colonization to utilize western languages to their benefit, some Sub-Saharan African countries declared these colonizing western countries languages as the main country languages to communicate between the tribes (Adedeji, 2015). Academically, children are taught these languages at an early age so that by high school they are able to speak and write in these languages proficiently. Additionally, all textbooks and education civility are based on these languages (Conteh-Morgan, 2001). For example, French is the country language medium

of academic and scholarly mode of communication in Algeria, Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, and the Democratic Republic of Zaire (Marsicano, Lydie, & Bajos, 2011). Sub-Saharan English speaking countries include Nigeria, Zambia, Uganda, Botswana, Namibia, Kenya, Sierra Leone, South Africa, Lesotho, and Swaziland.

Immigration from Africa to Western Countries

Citizens from these previously colonized countries, due to fluency in their European based languages, tend to migrate to those countries who speak the same language. Sub-Saharan African nationals who speak French tend to migrate to French-speaking European countries (Lessault & Beauchemin, 2009; Ziltener, Künzler, & Walter, 2017). English speaking countries commonly migrate to European English-speaking countries (Omamegbe, 2010).

African Customs of Marriage

Marriages in Sub-Saharan Africa vary depending on religion, tribes, economic status and tradition beliefs. Homosexuality has never been part of African Culture as an open tradition cultural practice; needless to say, homosexuality may have existed in secrecy. The heterosexual relationship is the basis and foundation of African marriages (Epprecht, 1998; Gaudio, 2014). In various Sub-Saharan countries, arranged marriages are still being practiced (Sam, 2009). The approved age to marry is customarily based on tradition - for boys 18 years and older and girls 12 years and older - though now due to European influence, the age range has now increased. Types of marriages are either with one wife or many wives (polygamous) with the bridegroom frequently paying the bride

price (Meekers, 1994). Polygamy has been present in Africa for centuries as part of the traditional belief, religion, and culture (Thobejane, 2016). African chiefs and their kings had envisioned having many children as a sign of power and wealth. The more children the family had, the more land was cultivated, more animals reared, the bigger the community, and the more the power and influence in the community (Matz, 2016). Currently, though the polygamous culture has decreased due to European and Christian influence, the culture of polygamy and the traditional belief system surrounding it remains potent and part of Sub-Saharan African natural rearing and childhood credence (Matz, 2016).

HIV in Sub-Saharan Africa

Studies performed by Aral (2010) and Kalichman et al. (2007) investigated why HIV was rapidly disseminating faster in Africa than any other part of the world. Results from these and other studies (e.g., Mah & Halperin, 2010; Tibesigwa & Visser, 2015) found that the population was inclined to have more concurrent sexual relationships than any other population. Bene and Darkoh (2012) pointed out that the traditional cultural prestige that embraces the desire to have many children through the traditional beliefs of polygamy and other African culture and beliefs that contributed to compromising of promiscuous behavior than in the west. However, other studies rejected the theory of fast spread of HIV due to concurrent sexual relationships in Sub-Saharan Africa (Sawers, Isaac, & Stillwaggon, 2011; Tanser et al., 2011). Other studies indicate this is due to poor education and that women who are poorer are more likely to live in polygynous marriages. In Kenya, for example, studies have indicated that HIV thrives in Sub-Saharan

Africa due to early sexual relationships. Westercamp, Mattson, and Bailey (2013) reported one out of every four men under the age of 24 years had their first sexual encounter before the age of 15. Among women aged 25-29, sexual activities begin between 16 to 17. Fueled by poverty, lack of education, multiple sexual partners, and polygamous culture this has made the Sub-Sahara a breeding ground for sexually transmitted diseases and HIV (Kretzschmar & Carael, 2012; Sandoy, Dzekedzeke, & Fylkesnes, 2010).

HIV Among Sub-Saharan African Men in the United States

Sub-Saharan Africans who migrate to the United States normally undergo laboratory analysis including their HIV Status (Ogungbade, 2010; Sides, 2006). African-born immigrant adults and children with the intention to migrate to the United States are screened for HIV and those found HIV positive are denied a visa except for other health necessity (Lemoh et al., 2013; Ogunjimi, 2017; Sides, 2006).

Upon arrival in the United States, African-born immigrants possess a culture and belief system that is unique when compared to Americans (Amadi, 2012; Musyoka, 2014; Nsangou & Dundes, 2018). These include acknowledgment of a polygamous view of the heterosexual relationship and acceptance of a multiple partner relationship (Ogunjimi, 2017; Reniers & Tfaily, 2012). Consequently, when African-born immigrants come to the United States and are unhinged by culture and traditions that held them back for accountability, after they establish themselves with jobs they also establish concurrent heterosexual relationships (Kenyon, 2012). However, since these relationships are ambiguous and African-born immigrants traditionally and culturally are predestined to

having multiple partners, these relationships escalate thereby morphing into wider web of heterosexual relationships until they become an underlying determinant conduit for HIV transmission (Cassels, Jenness, & Khanna, 2014; Fox, 2014; Reniers & Tfaily, 2012).

Summary and Conclusions

Since HIV was first diagnosed in 1981 in the United States, infection rates among Black Americans continue to be higher than among the non-Black population. The HIV rate among African-born residents continues to escalate and the incidence of HIV among Blacks in the United States has been catapulted by African-born U.S. residents (Blanas et al., 2013). Currently, the literature lacks research that differentiates how Sub-Saharan Africans contract HIV while residing in the United States. The purpose of this study was to identify themes from life experiences of Sub-Saharan African men using grounded theory to analyze constructs of risk-taking behavior that predispose them to contract HIV. The HBM guided the current study to synthesize the perceived susceptibility, severity, and self-efficacy in relation to knowledge, attitudes, and beliefs of Sub-Saharan African men who have HIV. Chapter 3 will present the research design, methodology of the study, and issues of trustworthiness.

Chapter 3: Research Method

Introduction

This chapter provides a detailed narrative description of the study and purpose for the research methodology used to examine knowledge, attitudes, beliefs, and behaviors aligned with the spread of HIV among Sub-Saharan African-born immigrants. A qualitative approach of inquiry was used to explore in depth the life experiences of Sub-Saharan African men. My responsibility in this study was to gather data while providing confidentiality and preventing bias. The sample population was first-born generation African-born men from Sub-Saharan Africa who resided in the United States. The research and data-collection methods were described to potential participants to promote understanding of the purpose of the research. This chapter will end with an explanation of protocols used to secure ethical considerations and the protection of human subjects for this study.

Research Design and Approach

Mixed-methodology researchers investigate a given hypothetical question from various relevant angles, thereby making the mixed methodology more comprehensive (Creswell, 2013). The disadvantages of mixed methods research, however, is that it displaces quantified data when multidimensional qualitative codes are applied (Crosby et al., 2006). Furthermore, mixed methods can make constructs indistinguishable, thereby resulting into dichotomous variables (Johnson, 2015). Mixed methods research uses complex processes to evaluate unstructured data (Driscoll, Appiah-Yeboah, Salib, & Rupert, 2007).

The purpose of this investigation was to use each participant's distinct life experiences with their contextual understanding during interviews to ascertain risk behavioral activities and other related factors that expose first-generation Sub-Saharan Africans to HIV. Interviews were selected over focus groups because discussions about sexually related behaviors in the culture of Sub-Saharan Africans are considered unacceptable in daily conversation (Kerani et al., 2008). Individual interviews can facilitate a trusting relationship built between the interviewer and the participant (Blanas et al., 2013). Individual interviews are essential as participants can describe their experiences without being influenced by other people's perceptions (Harawa et al., 2002).

The knowledge, behaviors, attitudes, and beliefs of Sub-Saharan African-born U.S. immigrant men were explored using a qualitative conceptual framework of grounded theory. To explain and understand events that relate to life experiences, grounded theory can effectuate and clarify phenomenon (Crosby, DiClemente, & Salazar, 2006). One can explore in depth perceptions of behavior, motivation, attitudes, and individual opinion inductively in qualitative research (Schiavo, 2007). Researchers cannot deduce behavioral constructs independently because the authenticity of collected data requires a qualitative methodology to describe experiences. Researchers can apply a qualitative approach to illustrate the objectivity of relationship, human interaction, social narratives, individual milestones, and obscure phenomena (McKenzie, Neiger, & Thackery, 2009). Qualitative research promotes deductive reasoning and has a broader application in that it encompasses a deeper perception in the constructs of the phenomenon that cannot be achieved by quantitative research (Crosby et al., 2006).

Qualitative and quantitative research have limitations; however, each research method becomes essential, depending on the phenomenon under investigation (Polkinghorne, 2005).

In view of these perceptions, I selected a qualitative-research approach for this investigation over a mixed approach or quantitative methods. Qualitative approach robustness rests on gathering verbal data and answering *why* questions in depth (Creswell, 2013). In this study, because I examined attitudes, beliefs, and risk behaviors, a qualitative approach was appropriate, allowing the theoretical premise of interpreting the construct of human experience (Hunt & Morgan, 1995). Qualitative research provides description and textual understanding of how individuals perceive their experiences, cultural beliefs, and values in the social context of the population under investigation (Fryer, 1991).

Qualitative research has four main approaches: ethnography, phenomenology, field research, and grounded theory (Creswell, 2007). The ethnographic approach emphasizes observations in the context of individuals, populations, or organizations. Ethnography could not be used in this study due to the assumption that Sub-Saharan African-born immigrant men may have different religious and cultural beliefs that may differentiate their life experiences. The phenomenological approach focuses on individuals' subjective experiences and interpretation of their surroundings. This approach attempts to understand how the world appears to others and consequently, researchers employ a case study or a narrative approach to investigate a phenomenon (Creswell, 2007). Phenomenology did not qualify for this study because the approach

seeks to reflect on the structure of the experience with limited sampling strategies. Field research also could not be used for this study due to the researcher being in the field for observations (Creswell, 2003).

The qualitative conceptual framework of grounded theory was selected for the study because the approach considers qualitative data from interviews to generation theory (Glaser & Strauss, 1967). The grounded theory process of data collection and analysis persists until the researcher assesses having reached maximum saturation of data (Van Maanen, 1983). Grounded theory thereby grants validity and strong conceptualization in explaining phenomenon.

Role of the Researcher

The objective of the current study was to comprehend risk behaviors, actions, and associated factors that cause the spread of the HIV through life experiences among the first-generation Sub-Saharan African-born immigrant male population 20 years of age and older. My role in this study was to manage all aspects of the investigation including the design, research, and protection of study participants from bias, abuse, and any detriment. Researchers in qualitative studies describe, decode, and interpret the meaning of phenomena taking place in the social context (Creswell, 2003). In this study, I analyzed the structure of investigation, contextualization, authenticity, and minimization of bias, and interpreted the data. In addition, I identified contextual factors as they relate to the phenomenon of interest. I used grounded theory to inductively generate a tentative theory associated with the phenomenon. The gathered data, grouped themes that repeat themselves, and elements of data found to be repetitious were arranged into categories. I

coded the categorical constructs and use the codes to generate new theory. Although this was my initial investigation, I have ensured that the research has objectivity, validity, and conformability, and eschews bias. Creswell (2013) noted that using a personal journal to document post-interview comments may protect the study from bias. Therefore, to avoid bias, I wrote journal notes containing personal insights related to the causes of the spread of HIV in Sub-Saharan African-born immigrant men.

Methodology

Sampling a population is a process of distinguishing the subgroup that is a representative of the actual population (Patton, 2002). To warrant adequate statistical analysis the represented population should be of sufficient sample size. The population chosen for this study was a homogenous sample from Sub-Saharan African-born men who migrated to the United States as the first-generation. Interviews were conducted in Delaware Valley. I requested permission from organizations such as churches and African associations groups in which African-born immigrants congregate. Interviews were conducted at libraries adjacent to convenient sampled participants' communities. Study participants who have been naturalized as residents of the United States were selected. Qualitative data analysis involves procedures of categorizing and translating the meaning of phenomenon (Patton, 2002). Ogunbade (2010) purported that experiences in the belief of how HIV is transmitted, commensurate actions, and related factors that caused the disease are phenomena that can only be deduced, reflected, and explained with an understanding of perceived risk behavior by participants.

Confidentiality was essential in the current study. Creswell (2009) proposed researchers hold confidential any information received from study participants and will reveal no personally identifiable information about participants. To ensure anonymity, the participants' identities were numbered and concealed. The interviews took place at the public library and community center after gaining permission to recruit them.

I placed flyers strategically in meeting rooms, churches, associations, and restaurants where African-born immigrants congregate. A copy of the advertised flyer appears in Appendix C. The flyers indicated the reason for the study, requesting interested people to apply to participate. The flyers also mentioned selection criteria and contained telephone and email contact information. Biernacki and Waldorf (1981) suggested using the snowball-sampling technique when performing investigations in environments with a population that wants to remain anonymous or difficult to access. In snowball sampling, respondents who agree to participate in the study recruit other subjects from their acquaintances (Goodman, 1961). For this study, I used the snowball-sampling technique to maintain confidentiality.

English was the language of communication selected for the interview and participants had to be able to articulate clearly and efficiently. English proficiency is necessary to ascertain meaning of constructs from lived experiences, and deduce coherent concepts, essences, and themes for data analysis. Interested potential participants contacted me. When talking to interested participants, I substantiated if they fulfill the inclusion criteria and reassured them that involvement in the study would be voluntary. I informed interested people that participation would be discretional, involve a 2-hour

interview, anonymity and confidentiality would be paramount, their personal narrative answering semi-structured questions would be audio recorded, and the entire process and derived responses would be kept confidential. I asked each participant which days they were available for an initial meeting, their transportation status, and disclosed the location for the meeting. As the investigator, I emphasized that it was of the utmost significance that they honestly, freely, objectively narrate from lived experience, and disclose their perception of how HIV is being contracted in the community. On the day of the initial meeting, each participant signed an Institutional Review Board (IRB) disclosure of confidential information and research stipulations. I also disclosed that if the participant felt vulnerable or did not want to continue with the interview at any time, they should let me know and they would freely exit the interview. After this explanation, the interview commenced.

Instrumentation

This study used semi-structured interviews to collect data regarding how HIV spreads in first-generation Sub-Saharan African-born immigrant men. The research questions were:

1. What are the knowledge, attitudes, beliefs, and behaviors that facilitate the transmission of HIV among men who are Sub-Saharan African-born immigrants?
2. What factors contribute to the spread of HIV among Sub-Saharan African-born immigrant men?

3. What are the activities and actions in which Sub-Saharan African-born immigrant men are involved that predispose them to HIV?

According to Patton (2009), semi-structured interviews are most appropriate to contrive theory in a population that is inconspicuous. To collect the data, I arranged interviews with each participant to last 2 hours. Questions were structured so that I asked questions that would yield greater insight and description. Subsequent open-ended questions generated knowledge of depth in the phenomenon.

To gain insight into the lived experiences of Sub-Saharan African-born male immigrants, the first question was asked in three stages. First, I asked participants to describe their daily life prior to coming to the United States. Next, to ascertain their attitude toward HIV, I asked about their attitudes about people with HIV. To determine their beliefs regarding sexuality, I asked how many sexual partners they have had, where they go to find sexual partners, what characteristics they seek in a sexual partner, and how frequently they engage in sexual activities. In addition, I asked if they had engaged in oral sex, anal sex, sex with another man, have paid money for sex, and whether they have used condoms. To determine other risk-taking behaviors, I asked participants about their involvement in the use of illicit drugs (cocaine, marijuana, heroin, prescription drugs, alcohol, or amphetamines) or distribution of drugs.

The second question on the data-gathering instrument ascertained what factors contribute to the spread of HIV among Sub-Saharan African-born immigrant men. First, I asked participants what kind of feelings they experienced since arriving in the United States. To prompt this response, I encouraged participants to think about their first few

months in the United States. I asked them to describe their feelings and emotions. This question aimed to deduce their perception of emotional expressions of loneliness, boredom, support systems, fear, doubt, and financial strain (see Appendix D for the interview guide).

The third question on the data-gathering instrument asked about the activities and actions in which Sub-Saharan African-born immigrant men are involved that predispose them to HIV. I asked participants to describe the activities in which they participate in on a daily basis. I prompted them to discuss their work, home, and social activities such as parties, weddings, and social gatherings. I used this question to generate belief system in understanding of their interpersonal relationships that may have predisposed them to contract HIV.

Pilot Study

Before the data collection, I conducted a pilot study to ascertain valuable information about the epistemological strength of the study questions. Pilot studies evaluate the tools for collecting data and research protocols and provide insight into the effectiveness of the test questions (Creswell, 2009). According to Patton (2002), prior to the formal study, the researcher should select a subset of the population that is representative of the study group.

For the pilot study, a convenience sample of four Sub-Saharan African-born immigrant men were recruited in Delaware Valley at locations where Sub-Saharan African-born immigrant men gather. Participants were informed of the date, time, and location of the pilot study. This group setting allowed me to test the questions to assess

study construct elements. During the pilot study, participants attended the session once taking 2 hours for each period to discuss the strengths and weaknesses of the questions. Ideas from the pilot study increased the credibility of capturing clearer findings in the main study. In addition, the pilot study assisted me in achieving cultural competence with regard to behavior, attitudes, and beliefs among Sub-Saharan African-born immigrant men; consequently, I acquired skill in better questioning techniques and understanding of participants' backgrounds and lived life experiences.

Questions were revised after the pilot study to assure the formal study obtains purposeful data. This pilot study also provided me with unique approaches and intimations that I was not able to foresee prior to conducting the pilot study. According to Creswell (2009), pilot studies permit a sublime check of the anticipated statistical and analytical procedures, providing a researcher a better ability to analyze the data.

Procedure for Recruitment, Participants, and Data Collection

The procedure for recruiting participants was initiated only after IRB approval. The IRB reviewed various documents and activities that related directly to the welfare and rights of participants in the proposed investigation including the research design, methods, and instrument I used in the study. In this study, recruitment of study participant was equitable. No participants were excluded from the study on the basis of their national origin, creed, education, or socioeconomic status. No monetary incentive was offered to study participants except transportation cost.

The IRB protocol guide for human-participant recruitment was used. I used a flyer to advertise the pending investigation. The flyer indicated that the purpose of the

study was to investigate how HIV spreads among the Sub-Saharan African-born immigrant male population. Benefits of the study were indicated to gain information that may help prevent the spread of the disease in the Sub-Saharan African-born immigrant male population. Results from the study were announced to be used to generate educational information and to assist in devising preventive strategies and materials that could be used in the Sub-Saharan African-born immigrant male population.

Flyers were placed in the hallways of the church organizations and association groups or clubs that cater to this population (see Appendix C). The flyers indicated the reason for the study and requested interested people to apply to participate. The flyer also included the selection inclusion criteria. Flyers included the researcher's telephone and email contact information for interested people. I am not associated with the organizations that cater to these communities. After two weeks of waiting for communication from interested volunteers, I selected 14 participants. I scheduled initial meetings with each participant (see Appendix B and G) at which they signed IRB forms (see Appendix A) and research consent forms (see Appendix F). Each participant attended interviews three times and each session lasted approximately 2 hours. Three sessions were necessary for this research due to use of the grounded theory methodology, which requires a point of saturation to derive the maximum construct to generate theory from categorical elements. Theoretical saturation in qualitative research means the researcher reaches a point in their evaluation of data that generating more data does not lead to more information to increase validity to answer the research question (Glaser & Strauss, 1967).

Study participants responded to questions designed to answer the research questions. I used a question guide to prompt participants to provide life-lived experiences to assist in discovering how HIV spreads in the Sub-Saharan African-born immigrant male population. Kwakwa and Ghobrial (2003) noted that the African traditions of conservatism (avoiding talking about sex) tend to intensify HIV in the community; therefore, utilizing semi-structured interview was appropriate due to face-to-face confidence.

Study Population

The population for this study was 14 Sub-Saharan African-born U.S. male immigrants who resided in Delaware Valley. The 2014 HIV report (CDC, 2014) indicated that New York had 59.0% of Blacks, 12.8% of Whites, and 35.0% of Latinos/Hispanics living with the disease. The state of Delaware reported that 66% of Blacks, 28% of Whites, and 5% of Hispanics had HIV. New Jersey subsequently reported that 22% of Whites, 52% of Blacks, and 25% of Hispanics had HIV. The city of Philadelphia had 64.7% of Blacks, 20.6% of Whites, and 12.0% of Hispanics with HIV. Looking at the demographics of those with HIV in the Delaware Valley and New York, I noted that the HIV prevalence rates of people with the disease are higher among the Black population. Moreover, the CDC does not distinguish between African American Blacks and Blacks from the continent of Africa or the Caribbean, thereby rendering the population described in the data unclear (Kerani et al., 2008). Consequently, conjoined statistics make it difficult to delineate the progression of the disease in the Black population. Therefore, this study seeks to understand risk-behavior activities, actions, and

factors that contribute to the spread of the disease in the first-generation Sub-Saharan African-born immigrant male community.

To recruit study participants, I used criterion sample. Inclusion selection criteria for this investigation included African-born men who (a) self-identified as having come from Sub-Saharan African countries, (b) resided in Delaware Valley, (c) 20 years of age or older, and (d) U.S. residents. To understand the impact and magnitude of prevalence rates of HIV among African-born population, the data was collected, delineated, and investigated to determine the trends of HIV rates based on the country of origin (Kwakwa et al., 2012).

The validity of a qualitative study can be reinforced with structured or semi-structured interviews (Kirk & Miller, 1989). The interviewer in a semi-structured interview follows a guide but may adopt the topical trajectories in the discussion that can deviate from the guide, subsequently capturing the richness of the interview (Bernard, 1988). For this study, I used semi-structured interview questions (see Appendix D) to collect data on risk behaviors and factors that made the Sub-Saharan African-born immigrant men susceptible to HIV. To ascertain the appropriate sample size for this study, Patton (2002) and Creswell (2009) advised qualitative research has no guidelines for sample size. Sample size should rest on what a researcher wants to know, the purpose of the investigation, time, resources, and credibility of the study. Creswell (2009) suggested that in robust qualitative studies, applying a grounded theory approach and obtaining a sample size between 10 and 20 participants can assist in generating theoretical saturation, which is essential for the reliability of the study. For this study, I

used a sample size of 14 participants. This sample size is appropriate to critique theoretical saturation, to analyze the core principle of the study, and to build a budding theory from categorical themes emerging from the data (O'Reilly & Parker, 2012).

Data Collection Methods and Rationale

To gather data for this study, I conducted semi-structured interviews (see Appendix D) and used a static theoretic sample. Theoretical samples and grounded theory are congruous because researchers select participants with the intent to facilitate theory development and understanding of the area of investigation (Glaser & Strauss, 1967). In qualitative analysis, static samples are appropriate because the approach engages a criterion that is fixed to determine whether it is a suitable representation of the large original database (John & Langley, 1996). Therefore, a static sample was convenient for this study to allow a fixed sample without requiring additional study subjects to be injected into the study. I selected interested participants for face-to-face semi-structured interviews that were audio recorded. The recording of study participants involved audio taping narratives and responses to study questions. Grounded theory was the instrument used in collecting data. The purpose of adopting grounded theory in this research was to consider qualitative data, derived from interviews, to generate inductive theory.

Issues of Trustworthiness

Chiovitti and Piran (2003) noted that in qualitative research issues of trustworthiness can be achieved and realized by analyzing data for validity. In this study, to increase reliability and validity, an experienced and qualified researcher worked with me to ensure approaches to the study were authentic and cogent. The concept of

trustworthiness ensures that research development conforms to credibility, transferability, and dependability. In addition, in order to appropriately interpret result configuration from NVivo software, an experienced skilled proficient NVivo expert assisted me to professionally understand and to interpret the results.

Credibility

Credibility in the study indicates that the results of the research project will be reliable and convincing (Ravitch & Carl, 2016). Shenton (2004) noted that credibility signifies the quality of work based on the richness and depth of information collected. Moreover, other techniques may be involved in ensuring data accuracy such as member checking and thorough triangulation of multiple analyses. In this qualitative study, NVivo was invaluable in assisting the researcher index section of the study - especially linking themes to coding. In addition, NVivo aided me in exploring the possible association between the themes and study outcomes, therefore, increasing the reliability of the study.

Transferability

Ravitch and Carl (2016) described transferability in qualitative studies as how transferable the research study is and how it can be replicated in the environment if the same data and concepts were utilized. Nevertheless, transferability has limitations in qualitative studies mostly due to decreased sample understudy. Time may also limit transferability due to impact on season, era, age, and epoch of a generation. Situations can affect replicating the study especially if the culture or inhabitants have evolved into a unique spectrum that does not exist anymore. People and other related species may affect transferability due to diminishing or declining of species under study (Shenton, 2004).

This study conducted semi structured interviews with a convenience sample who annotated their perception of the phenomenon from lived experiences. In addition, Ravitch and Carl (2016) analyzed the concept of transferability in that researchers conducting the qualitative outcomes can utilize interviews to formulate the depth in the perception of the phenomenon and be able to replicate the study.

Dependability

Ravitch and Carl (2016) noted that dependability enables that study findings are reliable and dependable. Dependability can be measured within customary prevailing research as it is being conducted, analyzed, and presented. Shenton (2004) explained how dependability in qualitative research procedures should be described and be conveyed in detail to enable an external investigator to replicate the inquiry to ascertain similar study outcomes. In this study, dependability allowed me to comprehend and recognize the effectiveness of research tools such as methodologies, NVivo, and research design.

Confirmability

Shenton (2004) reported that confirmability questions the legitimacy of research findings and how they are reported and described in data collection. The significance of confirmability procedures is based on the principles of analyzing whether the investigator introduced bias in the study due to the fact that qualitative procedures permit the investigator to create a distinct perspective and assessment to the scholarly research. Ravitch and Carl (2016) posited that in order to annotate confirmability an external investigator aspiring to replicate the study can analyze the data collected during the

original interview. In this study, confirmability was initiated during data collection, data analysis and when reporting data outcomes.

Ethical Procedures

Tanja (2011) performed a study in which they found that lack of ethical rigor deformed the credibility of the study; however, in this study ethical principles were the cornerstone and credibility of the research. Participants in this study were first-generation Sub-Saharan African-born men U.S. Immigrants. Prior to their involvement in this research, they were asked to sign informed consent and confidentiality forms. The principle of anonymity is essential to grant privacy and I explained this right to participants. The principle of voluntary participation states that participants should not be coerced to participate in research. I explained the participants' right to them, indicating that they are free to elect whether to participate in the study. In this investigation, no clinical test was conducted and participants likely had no detriment or impairment from participating in the interviews. All necessary research documents, audiotapes, interview transcripts, diaries, and files are locked in a file cabinet, as instructed by Walden University protocol. The noted items will be kept in the locker for 5 years as evidence for generated research findings. Prior to initiating research, I obtained approval to conduct the study from the Walden University IRB (11-17-16-0257092). Upon IRB approval, the study commenced. The IRB notes that ethical considerations for study participants are to be given priority: confidentiality, informed consent, privacy, and safety.

Summary

Chapter 3 presents various topics that are included in the study: the research design, methodology, instrumentation, pilot study, procedure for recruitment, data collection, data analysis, and issues of trustworthiness. The purpose of the study was to ascertain risk taking behaviors, activities, and factors that have increased the spread of HIV among the Sub-Saharan African-born immigrant male population. Semi-structured interviews were conducted to collect data from participants. I interviewed a homogenous sample of 14 African-born U.S. residents about their lived life experiences. Qualitative grounded theory was used to generate categorical constructs, themes to initiative inductive theory, and deduce the factors that contribute to the spread of HIV in the first-generation Sub-Saharan African-born immigrant male population. I used NVivo software to translate categorical elements into meaningful data to describe, explain, and understand phenomenon. Prior to main data collection, I tested interview questions through a pilot study to ascertain validity, reliability, research bias, and cultural competence related to the questions. Prior to the study, I explained ethical considerations including confidentiality, anonymity, principles of voluntary participation, consent, and the right to privacy to participants and the IRB. The study began following approval of Walden University's IRB. Chapter 4 will discuss study findings and data interpretation in relation to the phenomenon.

Chapter 4: Results

Introduction

The purpose of this grounded theory study was to explore the factors that may predispose first-generation Sub-Saharan African-born men living in the United States to risky sexual behaviors that may place them at risk of becoming HIV infected. Three research questions were used to guide the study.

1. What is the perceived susceptibility that predisposes Sub-Saharan Male African Immigrants to sexual risk-taking behaviors when they come to the United States?
2. What are the perceived cultural safeguards (cultural, social, and economic) that existed in Africa that are absent in the U.S. and has exposed African-born U.S. residents to HIV?
3. What does the African immigrant male perceive to be dissonant in the U.S. culture that promoted risk-taking behavior? [Cultural dissonance is an uncomfortable sense of discord, disharmony, confusion, or conflict experienced by people in the midst of change in their cultural environment].

Chapter 4 includes a description of the setting of data collection, followed by a description of the relevant demographic characteristics of the study participants. Next, chapter 4 includes descriptions of the implementation of the data collection and data analysis procedures discussed in chapter 3, followed by a discussion of the evidence of the trustworthiness of the study's results. Chapter 4 then includes a presentation of the

results of the study, which is organized by research question. The chapter concludes with a summary.

Pilot Study Results

Before initiating the study, a pilot study was conducted to analyze reliability and construct validity of research questions, data collection methods, and related research instruments. The pilot study was used to ascertain whether the semi-structured interview protocol and research questions were culturally appropriate to yield the needed research data and research outcomes.

To implement the pilot study, the advertisement related to the study was circulated among community organizations that serve Sub-Saharan African immigrants in the state of Delaware. Four individuals responded but only two were chosen, per pilot study requirement. A semi-structured interview was conducted and recorded with these two pilot study participants. Pilot study outcomes indicated that study instruments were reliable, valuable, culturally appropriate, and applicable. Based on the pilot study outcomes, no amendments or modifications to data collection methods were necessary.

Setting of Actual Study

Interviews were conducted one-on-one and face-to-face at times and places of the participants' choice. Participants were allowed to choose the location of their interview so they would feel as safe and comfortable as possible, to increase the likelihood that they would give full and rich responses to the interview questions. Similarly, participants were allowed to choose the time of their interview so they would not feel rushed by pressure to attend to other obligations, again so they would be able to give complete responses.

Finally, participants were assured that their identities would remain confidential, to increase the probability that they would be honest in their responses.

Demographics

Study participants were 14 African-born men who (a) self-identified as having come from Sub-Saharan African countries, (b) resided in the Delaware Valley, (c) are at least 20 years old, and (d) are U.S. residents. All participants reported that they were heterosexual. See Table 1 for the sample profile indicating the distribution of ages, marital statuses, income and education levels, and employment statuses.

Data Collection

I conducted one face-to-face, semi structured, one-on-one interview was conducted with each of the 14 participants. Interviews were audio-recorded with participants' consent. The duration of the interviews ranged from approximately 30 to approximately 45 minutes. There were no deviations from the data collection procedures described in chapter three and no unusual circumstances were encountered during data collection.

The sample size of 14 was used because data saturation was achieved with 14 participants. Theoretical saturation in qualitative research means the researcher reaches a point in their evaluation of data that generating more data does not lead to more information to increase validity to answer the research questions (Glaser & Strauss, 1967). In the present study, no new ideas or themes emerged during analysis of data from interviews 13 and 14, indicating that saturation had been achieved.

Table 1

Demographic Profile Distribution

Demographic	Count (%)
Age	
20-29	1 (7%)
30-39	6 (43%)
40-49	2 (14%)
50-59	3 (21%)
60-69	2 (14%)
Marital Status	
Single	2 (14%)
Married	12 (86%)
Income Level ($)	
10,000-19,999	6 (43%)
20,000-29,999	1 (7%)
30,000-39,999	2 (14%)
50,000 and above	5 (36%)
Education	
Completed Grade 9, 10 or 11	3 (21%)
High School Diploma/GED	1 (7%)
Associate Degree	3 (21%)
Some College	2 (14%)
Bachelors or above	5 (36%)
Employment Status	
Employed	8 (57%)
Self-employed	4 (29%)
Unemployed	1 (7%)

Table 2 Demographic Profile of Participants

Name	Gender	Age	Marital Status	Education	Annual Income US$
1EP	Male	28	Married	Bachelors	40,000
2SP	Male	53	Married	Associate	20,000
3TP	Male	45	Married	Grade 9	20,000
4LP	Male	68	Married	Grade 11	20,000
5KD	Male	32	Single	Grade 12	19,000
6EN	Male	47	Married	Associate	40,000
7SP	Male	35	Married	Associate	20,000
8KD	Male	32	Married	Associate	60,000
9ND	Male	57	Married	Grade 12	20,000
10SP	Male	48	Married	Bachelors	60,000
11KD	Male	37	Single	Grade 12	30,000
12NP	Male	64	Married	Masters	60,000
13CD	Male	36	Married	Masters	60,000
14ZD	Male	38	Married	Masters	60,000

Data Analysis

Recorded interviews were transcribed verbatim and transcripts were uploaded into NVivo 12 software for analysis. Data were analyzed using the grounded theory method described by Strauss and Corbin (1998). The first phase, open coding, involved categorizing data by analyzing each statement in each transcript for significance, differences, and similarities in comparison to other statements (Strauss & Corbin, 1998), and thereby identifying tentative themes. The next step was axial coding, in which themes were selected, compared to each other, and further refined (Glaser & Strauss, 1967). The third phase, selective coding, involved analyzing the axial themes for the core variables that characterized the phenomenon. Specific results of each phase of the coding process are provided in the presentation of the results below.

Issues of Trustworthiness

Procedures used to enhance each of the four elements of trustworthiness described by Ravitch and Carl (2016) are discussed in the following sub-sections.

Credibility. The findings in a study are credible to the extent that they accurately represent the reality they are intended to describe (Lincoln & Guba, 1985). To enhance the credibility of the study's results, I collected demographic information from potential participants to ensure that they met the study's inclusion criteria (see Appendix G). I also assured participants that their identities would remain confidential, to encourage participant honesty.

Transferability. The findings from a study are transferable to the extent that they would hold true in a different research context (Lincoln & Guba, 1985). Transferability must be assessed by later researchers because I am unaware of the specific circumstances to which other researchers may wish to transfer the results. To allow future researchers to assess transferability, I have provided detailed descriptions of the inclusion criteria for the sample, so that readers can judge whether data gathered from the sample are likely to be representative of other samples or populations. I have also provided detailed descriptions of the data collection methods I employed.

Dependability. The findings in a study are dependable to the extent that they would be reproduced by other researchers in the same research context (Lincoln & Guba, 1985). I enhanced the dependability of this study's results by providing detailed descriptions of the data collection and data analysis procedures I employed.

Confirmability. Confirmability is the extent to which a study's results are determined by the perceptions and experiences of the participants, rather than by characteristics of the researcher (Lincoln & Guba, 1985). To enhance the confirmability of this study's results, I have provided in-depth methodological descriptions to allow the integrity of the procedures to be assessed.

Results

This presentation of the results of the data analysis process is organized by research question, and within research question by axial code and open code. Results associated with research question one indicated the perceived susceptibility that predisposes Sub-Saharan Male African Immigrants to sexual risk-taking behaviors when they come to the United States. In relation to research question two, results indicated the perceived cultural safeguards (cultural, social, and economic) that existed in Africa that are absent in the U.S. and have exposed African-born U.S. residents to HIV. Results associated with research question three indicated the perceived dissonance in U.S. culture promoted risk-taking behavior in African-born immigrant males.

Theme 1: General Experience with HIV Transmission

The initial thematic category responses related to the general experience of how HIV is transmitted among Sub-Saharan Africans in the United States. The tables provide various responses with regards to the general knowledge of how HIV is transmitted among U.S. residents with origins from Sub-Sahara. These responses represent the relationship in knowledge attitude, beliefs and assumed behaviors of the African community. The indicated data is based on all 14 interviewed study participants.

Furthermore, from the data generated from the interviews, the data review different perception of how HIV is transmitted. Though each of 14 male participants stated how HIV is transmitted, results could be divided into two categories. Four of participants believed that HIV among Sub-Saharan African males in the United States was transmitted to this community when residents went to back to Africa on holiday to their indigenous homes; the other ten believed that transmission occurs within the United States.

Semantic Themes Extracted from Research Interview Responses

1. Explain your life experience after you had just arrived in the United States as an immigrant. Themes: dependent, independent, near homelessness, poverty, having nothing and lacked transportation.
2. After arriving in the United States what were daily routine experiences you began to perform? Themes: church, household chores, watched TV, bored.
3. What were your financial survival experiences? Themes: no money, poor, in poverty and fasting.
4. What was your social support group and how did they provide for your needs? Themes: Mother, Aunt, Friend, Uncle.
5. What were the strengths and weaknesses of support group or friends you noticed? Themes: No guidance to adapt to U.S.A life style, lacked familiar African foods, lacked warm clothing, lack of socialization, financial constraints and decreased support, decreased interaction and speaking English as a problem.

6. For socialization, what are some places you frequented or activities you involved yourself? Themes: weddings, bars, strip clubs, African Association and funerals.
7. What are cultural norms of sexual behavior you had in your home country and how have they differed between your home country and United States? Themes: heterosexual in Africa, homosexuality in the USA.
8. What's your views toward women/men in the United States compared with your view of women and men in your home country? Themes: In Africa men are the head of the household. Women and men have equal power in the household in the USA. Long working hours in America than Africa.
9. What kind of sexual relationship do you prefer, with men or with women? Theme: Prefer sex only with women.
10. What are differences between sexual relationship you have in the United States and your home country? Do you think it would be easier to find a sexual partner for a night in the United States or Africa? Themes: both in Africa and USA.
11. In Your opinion how do you think African immigrants contract HIV? Themes: unprotected sex multiple partners. Perception that there is no disease in America.
12. In your opinion do you think that African immigrants have a higher risk of contracting HIV when they go back to Africa on holiday? Or do you think

they have a higher risk of contracting HIV in the US? Themes: In Africa, In America, both in Africa and In America.

13. What symptoms do you think the African-born immigrant would begin to recognize that he has contracted HIV infection? Themes: weight loss, fever, I don't know.
14. What social behavioral activities do you think exposes African-born immigrants to contracting HIV? Themes: socializing in red light strip bars, African bars, African parties, American bars and using telephone sex houses.
15. Thinking about your African friends, do you think their fear of contracting HIV while living in the United States has affected their attitude towards use of condoms? Themes: attitude will be to use condom when in Africa, attitude will be not to use condom in USA because men want to have to true experience of having sex with an American woman.
16. Is there something else that you would like to add about factors that could potentially expose the African-born immigrants to HIV in the United States? Themes: HIV cannot be contracted in Africa because HIV infection is highly publicized. HIV is highly contracted in the USA because there is no publicity about the disease compared to Africa. USA no HIV/condom publicity. In Africa high level of publicity of use of condom on every radio station.

Research question 1. Research question 1 was: What is the perceived susceptibility that predisposes Sub-Saharan Male African immigrants to sexual risk-taking behaviors when they come to the United States? Thematic responses from

interview question #1, 2, 3, 4, and 5 were used to answer research question #1. The presentation of results related to this research question is organized by the axial codes or themes that emerged during data analysis. Within the presentation related to each axial code, the discussion indicates the open codes that were grouped into the axial code. Discussion of the selective coding phase is provided at the end of the presentation related to Research Question 1, as a comprehensive summary of the results and an answer to the research question.

Axial code 1: Experiencing inactivity and disappointment. Twelve out of 14 participants reported that their experiences and routines during the first months after their arrival in the United States involved a disappointment of the expectations that had motivated them to emigrate as noted in open code 2 (OC 2). Participants reported that they were unable to work while their green cards were being processed and that they were often bored, having nothing to do and few people to socialize with while they waited for permission to become employed. Participants indicated that solitude, boredom, and frustration of the kind they experienced during this phase of their immigration process may predispose African-born men to engage in risky sexual behaviors while residing in the United States. Table 3 and Table 4 indicates the open codes that were grouped into this axial code. Quotations from the data are then provided as evidence for the open codes and axial code.

Open code 1: Nothing to do. Five out of 14 participants reported that their first experiences in the United States after they arrived from Africa were disappointing because they had nothing to do while they waited for permission to work. 2SP described

his experience of having nothing to do in saying, “When I had just arrived from Africa at first, I was excited and then I realized I had nothing to do. Slept a lot since I had nothing to do.” 5KD described a similar experience, in which sleeping was used to pass the time: “I slept a lot, I had no one to socialize with except the host family … I was bored and tired of watching movies.” 8KD’s inactivity caused him to regret his decision to move to the United States, and he also described the use of sleep to pass time: “I wished I had not come to this country. I spent the first four months hibernating in the house of host family. I was cold and miserable.”

Table 3

Open Codes Contributing to Axial Code 1

Open Code (OC)	Participants contributing to open code
OC 1 Nothing to do	2SP, 3TP, 5KD, 8KD, 9ND
OC 1 Nothing to do except home chores	1EP, 4KP, 6EN, 7SP, 10SP, 11KD, 12NP, 13CD, 14ZD.
OC 2 Feeling disappointed	2SP, 3TP, 7SP, 8KD, 9ND
OC 2 Disillusion and disappointed	1EP,2SP, 3TP, 4KP, 5KD, 6EN 8KD, 10SP, 11KD, 12NP, 13CD, 14ZD
OC 3 Difficult with English	3TP, 5KD, 6EN
OC 3 Proficient in English	1EP, 2SP, 4KP, 7SP, 8KD, 9ND, 10SP, 11KD, 12NP, 13CD, 14ZD
OC 4Fasting	1EP, 10SP
OC 4 Not enough Food	2SP, 3TP, 4KP, 5KD, 6EN, 7SP, 8KD, 9ND, 11KD, 12NP, 13CD, 14ZD.
OC 5 Arrived with having nothing	4KP
OC 5 Arrived with little money and clothing	1EP, 2SP, 3TP, 5KD, 6EN, 7SP, 8KD, 9ND, 10 SP, 11KD, 12NP, 13CD, 14ZD.

Note: Participants (N = 14) Subject could provide more than one answer

Table 4 Numeric Computation

Open Codes Contributing to Axial Code 1

Open Code	No. of Participant Response	% of Participants
OC 1 Nothing to do	5	36%
OC 1 Nothing to do except home chores	9	64%
OC 2 Feeling disappointed	4	29%
OC 2 Disillusion and disappointed	12	86%
OC 3 Difficult with English	3	21%
OC 3 Proficient in English	11	78%
OC 4 Fasting	2	14%
OC 4 Not enough food	12	86%
OC 5 Arrived with having nothing	1	7%
OC 5 Arrived with little money and clothing	13	93%

Note: Participants (N = 14) Subject could provide more than one answer

Open code 2: Feeling disappointed. Four out of 14 participants expressed that their early experience of residing in the United States was characterized by a profound sense of disappointment. 6EN used strong figurative language in describing his feeling of disillusionment: “My love for being in the USA turned into a nightmare. I experienced a very difficult life here before being established.” 14ZD referred explicitly to disillusionment in stating, “I became disillusioned with American dream.” 9ND described his realization that the opportunities in the United States were more difficult to find than he had expected: “My initial beginning was very difficult after arriving from Africa. I discovered that no one gives money for free in America.” (9ND)

Open code 3: Not knowing English. Three out of 14 participants reported that their isolation and inactivity during their first months in the United States were exacerbated by their poor command of the English language. 3TP stated, "Another thing that frustrated me was my English was not that good. So, during interviews I would repeat sentences and words just to make the interviewer listen to what I was saying." 6EN was also hesitant to participate in job interviews because of fears that he would be unable to express himself adequately: "Initially I have to confess my English was a problem and where I came from in Africa we never spoke English. In fact, I was scared to go for interviews." (6EN)

Open code 4: Fasting. Two out of 14 participants included that their inactivity during their first months in the United States included involuntary fasting due to financial hardship. 1EP stated, "Very difficult financially, I some days spent without eating proper food." For 10SP, fasting was a way to avoid making himself more of a burden to the people who were helping him: "To avoid bothering the host family for money, fasting became solution" (10SP).

Open code 5: Having nothing. One out of 14 participants indicated that his disappointment during his first months in the United States was exacerbated by the hardship of having nothing. Participant 4LP stated, "I was a refugee when I came USA as a result, we had nothing except the clothes we were wearing and few belongings."

Axial code 2: Depending on others to survive. Participants reported that they had to depend on other people for survival necessities after they arrived in the United States from Africa, and that experiences of hardship and dependence may predispose African-

born males to engage in risky sexual behaviors in the United States. Table 3 indicates the open codes that were grouped into this axial code. Quotations from the data are then provided as evidence for the open codes and axial code.

Table 5

Open Codes Contributing to Axial Code 2

Open Code (OC)	Participants contributing to open code
OC 6 Being dependent and vulnerable	1EP, 2SP, 3TP, 4LP, 5KD, 6EN 7SP, 8KD, 9ND, 10SP, 11KD, 12NP, 13CD, 14ZD
OC 7 Delayed permission to work prolonging dependence	1EP, 2SP, 3TP, 4LP, 5KD, 6EN, 7SP, 8KD, 9ND, 10SP, 11KD, 12NP, 13CD, 14ZD
OC 8 Associating independence with minimal hardship	7SP, 9ND, 10SP, 14ZD
OC 8 Associating independence with severe hardship	1EP, 2SP, 3TP, 4LP, 5KD, 6EN, 8KD, 11KD, 12NP, 13CD,
OC 9 Severely lacked transportation	1EP, 2SP, 3TP, 7SP, 8KD, 11KD, 12NP, 13CD, 9ND, 10SP.
OC 9 Depended on others for transportation	4LP, 5KD, 6EN, 14ZD

Table 6 Numbering Computation

Open Codes Contributing to Axial Code 2

Open code	No. of Participant Responses	% of Participants
OC 6 Being dependent and vulnerable	14	100%
OC 7 Delayed permission to work prolonging dependence	14	100%
OC 8 Associating independence with minimal hardship	4	29%
OC 8 Associating independence with severe hardship	10	71%
OC 9 Severely lacked transportation	10	71%
OC 9 Depended on others for transportation	4	29%

Note: Participants (N = 14) Subject could provide more than one answer

Open code 6: Being dependent and vulnerable. fourteen out of 14 participants reported that the condition of being dependent and vulnerable contributed to their susceptibility. 5KD described his financial situation as a dire one that forced him into dependency: “Financially, I was bankrupt, lost my independence and became completely dependent on my host family.” 11KD felt particularly awkward about imposing on his host, because their acquaintanceship was recent and not very extensive: “The host family was just an acquaintance I came across who was visiting Kenya. When I arrived, he had a low paying job and was not expecting me.” 14ZD felt guilty about his dependency because the people who supported him were also struggling financially:

> A friend of my mine I had met in Africa acted as host family but the problem was that he almost lived in poverty due to financial constraints. Therefore, joining him in his house made me become an extra burden to feed and to take care of. As a result, I really struggled. Sometimes eating a decent meal once a day or once in two days. (14ZD)

Open code 7: Delayed permission to work prolonging dependence. Fourteen out of 14 participants reported that their dependent condition was prolonged by delays in receiving legal authorization to work. 4LP stated, "It took 3 months before I was cleared for social security. This was a very difficult time of my life." 6EN described how the delay in receiving authorization to work exacerbated the discomfort of his dependency on a host family and eventually brought him into conflict with them:

> After settling down and 3 months without social security card, my host family started panicking. Finally, after my card arrived, I was told to go and work as nurse's aide so that I could settle quickly on my own. When I refused that I did not want to work in the nursing homes, I was told to leave their home. (6EN)

10SP had tried to mitigate the burden he represented to his host family by helping around the house, but he felt the inadequacy of this contribution:

> I thought I would compensate the burden of being a parasite by helping around the house, but still felt inadequate. Unfortunately, I have to say to wait for a social security card made the situation even worse. I spent more than 3 months in the house doing nothing but just helping with house chores. (10SP)

Open code 8: Associating independence with minimal or increased severe hardship. Four out of 14 participants found that when they received authorization to work and became independent, their low wages caused their suffering to minimize as they continued to live in host family home. On other hand, 10 participants noted that their suffering increased to severe after they received permission to work and found the low wage jobs host family told them to move out and become independent. Ten participants noted that their situation worsened because could not afford to pay rent, water, sewage, garbage and electricity from minimum wage they received. worse than had been the case in the host family's home. 2SP expressed the perception that his financial survival was in question after he achieved his independence from his host family:

> After I got the first minimum wage job I still could not solve my financial problems. But the host family still encouraged me to move out. Survival was very difficult in my initial part of life in America … I ended up working overtime on daily basis just to make it through the month. (2SP)

10SP also spoke of finding it difficult to survive financially after becoming independent of the family that had previously provided for him:

> After I got the [Social Security] card the nearby laundromat employed me to do work on clothes. I was getting minimum wage not enough pay rent. My host family encouraged me to move out of the house but when I started living alone I had no enough money to pay rent, electricity and food. I ended up on food stamps to survive. (10SP)

14ZD implied that he perceived his first independent accommodations as indecent: “My first job I got was minimum wage job as a result financially I was strapped for almost two years before I could find a decent accommodation.”

Open code 9: Severely lacked transportation or Depended on others for transportation.

1EP, 2SP, 3TP, 7SP, 8KD, 11KD, 12NP, 13CD, 9ND and 10SP indicated that they severely lacked transportation mostly due to financial constraints. Their host family rarely offered to take them for needed rides if they wanted to go somewhere especially job interviews. 11 KD mentioned “transportation was so severe that I had to walk between 5 to 10 miles to get where I was going”. 8KD noted that “I got tired of being lost by using the buses that where going different direction because of not knowing to where I was going and this resulted of me being late for interviews”.

4LP, 5KD, 6EN, and 14ZD reported that their experience of dependence on first coming to the United States involved being entirely dependent on others for transportation. These participants needed to rely on their host families either for rides in family cars or for bus or taxi fares, and they indicated that their ability to look for work depended entirely on their hosts’ willingness and ability to provide transportation. 4LP had missed interviews on occasion because of the challenge of obtaining transportation: “Even after I got my social security card, I missed a lot of interviews due to transportation problems. I had to wait for the host family to take me to the interview site.” 6EN described a similar experience: “I did not know the city or where companies I was applying to were located. Transport was a problem and I had to wait for host family to

take me to these interviews." 14ZD spoke of needing to schedule his interviews according to his hosts' availability to drive him:

> After my social security card arrived, transportation was a major problem. Buses were 3 miles away therefore, going for interviews was a major problem. To go for interviews, I had to wait till the host family were off work so that I could be taken to attend to interview. (14ZD)

This open code is distinct from

Open code 9. Depending on others for transportation, which included data indicating that the need for transportation was met or partially met by the host family. The present code included data indicating that the need for transportation was not met by the host family or any other source. 1EP's host family was unable to fund his public transportation: "The first weakness of the host family was that they did not give hard cash money that could have used for transport." 3TP felt that his host family did not meet his need for transportation because they did not take the initiative in making themselves aware of it: "The weakness of host family was that they did not try to find out my personal needs as a result I missed a lot of job interviews due to transportation constraints." 5KD spoke of having no way to commute to job interviews: "Transportation was one of the major problem I experienced. I had no way out to go for interviews." (5KD)

Table 7

Open Codes Contributing to Axial Code 3

Open Code (OC)	Participants contributing to open code
OC 10 Lacked socialization after arrival	1EP, 3TP, 4LP, 5KD, 7SP, 8KD, 12NP, 13CD, 14ZD
OC 10 Minimal socialization after arrival	3TP, 4LP, 7KD, 12NP, 14ZD
OC 11 Liked American food	7SP
OC 11 Did not like American food	1EP, 2SP, 3TP, 4LP, 5KD, 8KD, 11KD, 12NP, 13CD, 14ZD
OC 12 Had guidance how to adapt in America	10SP
OC 12 No guidance to adapt to life in US	1EP, 2SP, 3TP, 4LP, 5KD, 6EN, 7SP, 8KD, 9ND, 11KD, 12NP, 13CD, 14ZD
OC 13 Lacking warm clothing	1EP, 2SP, 3TP, 4LP, 5KD, 6EN, 7SP, 8KD, 9ND, 10SP, 11KD, 12NP, 13CD, 14ZD

Note: Participants (N = 14) Subject could provide more than one answer

Table 8 Numeric Computation
Open Codes Contributing to Axial Code 3

Open code	No. of Participant responses	% of Participants
OC 10 Lacked socialization after arrival	9	64%
OC 10 Minimal socialization after arrival	5	35%
OC 11 Liked American food	1	7%
OC 11 Lacked familiar food	13	86%
OC 12 Had guidance how to adapt in America	1	7%
OC 12 No guidance to adapt to life in US	13	86%
OC 13 Lacking warm clothing	14	100%

Note: Participants (N = 14) Subject could provide more than one answer

Axial code 3: Having unmet needs.

Open Code 10: Lacking socialization: In Table 4 indicates open code 10 of unmet needs grouped into the axial code. 1EP, 3TP, 4LP, 5KD, 7SP, 8KD, 12NP, 13CD, 14ZD expressed un met needs. Participants reported that their immigration to the United States had been characterized by the experience of having unmet needs, including needs for socialization, money, and guidance and this resulted into loneliness, boredom, and isolation. Quotations from the data are then provided as evidence for the open codes and axial code. 3TP described the experience of feeling excluded from his host family's social activities: "The weakness of host family was that they never included in me into family time like camping or when they decided to go out for some functions and this made me lonely and isolated." 8KD felt that his lack of socialization impeded his integration into his new community: "The weaknesses included lack of socialization this made stay home most of the time since I did not know the community." For 14ZD, the lack of socialization was exacerbated by timidity about venturing out alone in an unfamiliar place: "There was no social life or going out. I didn't know the community very well initially and was just scared to venture out by myself." (12NP). Only 2SP, 6EN, 11KD, 10SP and 9ND expressed having minimal socialization after arrival. 2SP noted that "Host family member friends would come and showed him how play basket-ball and football". 10SP mentioned "I always looked forward to Sunday to go a place of worship and this helped me to intact with other Americans". 11KD expressed that "On and off I went jogging with friends of host family members and watched neighborhood soccer games but it became boring as watched the same thing over and over".

Open code 11: Lacking familiar food or liking American food. Code 11 shows axial code of unmet needs of lacking familiar indigenous foods and liking American food as adjustment of to unmet needs. 7SP was unable to afford Sudanese food and quickly familiarized himself to American foods. 7SP stated, "I found Sudanese food very expensive, however, though I was not used to American food dishes soon I familiarized myself to eating pizza, sandwiches and spaghetti this change occurred because I had no money to buy African ingredients to make African foods." Other participants such as 1EP, 2SP, 3TP, 4LP, 5KD, 8KD, 11KD, 12NP, 13CD, and 14ZD expressed distaste of American food. Participants 4LP noted the following: "I had problem with American food due too much cheese. Every dish I tried had cheese on it and made me constipated for days." 8KD noted that "Initially American food was tasteless but sometimes later I had no choice but to eat it in order to survive." 12ND noted that "host family brought in TV dinners and spaghetti dishes which tasted like porridge every time I ate the dishes."

Open code 12: Lacking guidance. Another aspect of unmet need: was lack of guidance expressed in open code 12. Only 10SP expressed to had received guidance from the host family before making a big decision. 10SP noted that

> Even though I was not very close to host family I had to ask for their opinion before making a big purchase and this worked to my advantage. For example: the host family told me that Walmart Shopping Centre had the cheapest furniture and other kitchen related household products and as a result I avoided other shops and purchased affordable products when I started working for my small apartment.

Other participants such as 1EP, 2SP, 3TP, 4LP, 5KD, 6EN, 7SP, 8KD, 9ND, 11KD, 12NP, 13CD, 14ZD mentioned lack of guidance as to why they ended up making so many mistakes. Some of the major themes that came from participant on lack of guidance were noted mistakes such as: Poor tax filings, buying broken-run down cars, living in dangerous neighborhoods in which they got robbed that could have been avoided if there was continued guidance from host family. 7SP reported that he had needed and not received guidance from host family to orient him in his new community:

> The weakness of host family was that they never took time to show me the city vicinity or just to socialize in the nearby communities … I used to get lost all time. I did not know where I lived or where I was going to work and by the time, I got permission to work I did not know the surrounding neighborhood or the city I lived in.

Open code 13: Lacking warm clothing. All participants (N = 14) noted that they lacked warm clothing after they arrived in the US. Expressed observation from participants indicated that the situation was compounded by financial constraints and lack of host family support to provide them with warm clothes. 13CD lacked sufficiently warm clothing in a cold climate to which he was unaccustomed: "when winter came, my host family did not provide me with enough warm clothes. So, my first winter in the USA was very cold initially." 2SP noted that "I took cold weather for granted having come from a warm country and ended suffering frost bites to my feet because I thought I could walk long distances in cold weather without implications."

Axial code 4: Relying on risky behaviors for socialization. All participants reported the perception that, as a result of the factors associated with axial codes 1 - 3, African-born males residing in the United States were likely to congregate and seek companionship in venues where partners for casual sexual encounters were commonly available and to engage in risky sexual behaviors, including unprotected sex. Table 5 indicates the open codes that were grouped into this axial code. Quotations from the data are then provided as evidence for the open codes and axial code.

Table 9 *Open Codes Contributing to Axial Code 4*

Open Code (OC)	Participants contributing to open code
OC 14 Socializing in places where casual sexual partners were likely to be available	1EP, 2SP, 3TP, 5KD, 6EN, 7SP, 8KD, 9ND, 10SP, 11KD, 12NP, 13CD, 14ZD
OC 15 Not using condoms during intercourse	1EP, 2SP, 3TP, 4LP, 5KD, 6EN, 7SP, 8KD, 9ND, 10SP, 11KD, 12NP, 13CD, 14ZD
OC 16 Having unprotected sex with multiple partners	1EP, 2SP, 3TP, 4LP, 5KD, 7SP, 8KD, 9ND, 11KD, 13CD, 14ZD
OC 17 Having protected sex with multiple partners	2SP, 7SP, 8KD

Note: Participants (N = 14) Subjects could provide more than one Answer

Table 10 Numeric computation

Open Codes Contributing to Axial Code 4

Open code	No. of Participant's Responses	% of Participants
OC 14 Socializing in places where casual sexual partners were likely to be available	14	100%
OC 15 Not using condoms during intercourse	14	100%
OC 16 Having unprotected sex with multiple partners	11	79%
OC 17 Having protected sex with multiple partners	3	21%

Note: Participants (N = 14) Subjects could provide more than one Answer

Open code 14: Socializing in places where casual sexual partners were likely to be available. Fourteen out of 14 participants reported that isolation and boredom made African-born males residing in the United States susceptible to seeking companionship in venues where partners for casual sexual encounters were likely to be available. No participants reported that they themselves frequented the places in question, but rather described these venues as places in the United States where African-born males of their acquaintance might congregate. 2SP stated that some African-born males might socialize at, "Red light district clubs for women, social gatherings and nightclub for homosexuals." 8KD linked one kind of venue to HIV infection, saying, "African immigrants contract HIV … especially by visiting sex clubs." 11KD said that African-born males might contract HIV by, "Going to sex parlors," while 13CD referred to, "Red light strip clubs." 14ZD stated that African-born males might put themselves at risk by frequenting, "Single

strip clubs and African single parties which are frequently held among African born communities.

Open code 15: Not using condoms during intercourse. All participants stated that the high-risk sexual behavior most often engaged in by African-born males in the United States was unprotected intercourse. The most common sample quotation related to this open code was, "No condom in America." These words were used by 2SP, 3TP, 4LP, 5KD, 6EN, 7SP, 8KD, 9ND, 11KD, 12NP, 14ZD when asked what behaviors caused African-born males to contract HIV in the United States. 10SP indicated a circumstance under which a condom might be used, and implied that this circumstance might seem exceptional: "No condom in America, only use condom if they know possibility of pregnancy." 14ZD stated, "African immigrants practice unsafe sex in USA." (14ZD)

Open code 16: Having unprotected sex with multiple partners. Eleven out of 14 stated that the high-risk sexual behaviors of African-born males in the United States included "unprotected intercourse with multiple partners" these statements where stated by 1EP, 3TP, 4LP, 5KD, 7SP, 8KD, 9ND, 11KD, 13CD, and 14ZD. 2SP stated that African-born males may contract HIV in the United States by, "Having sex with multiple partners in USA without condoms. These immigrants do not have family here to tell them not engage in this behavior." 7SP used similar language, ascribing HIV infection to, "Having multiple sexual partners and having sex without condom." 8KD said, "African immigrants contract HIV in USA by having multiple partners." However, 6EN and 7SP note that it is possible: "African immigrants contract HIV by having unsafe sex in Africa and then come here and infect others." On other hand, 2SP, 7SP, 8KD mentioned that "I

know some African immigrants who use condom with multiple partners only if they are suspicious of other sexual transmitted diseases."

Open code 17: Having protected sex with multiple partners. The researcher wanted to know if any participants knew colleagues in the community who utilize protected sex during sexual encounter with multiple partners. Participants 2SP mentioned that "Out of all people I know from Africa only one of my friends uses condom during the encounter, but the rest don't." 7SP noted "one person I know only started using condom recently because one of her girlfriends told him she was pregnant, but fortunately she miscarried and lost her pregnancy." 8KD also noted "I know three of my best friends who at least have sex on daily basis with girls from different racial groups and they told me that they hardly use condoms." Themes that emerged from Participants 2SP, 7SP, 8KD were "very few Africans use condoms during sexual encounter with multiple partners."

Selective coding. Selective coding involved analyzing the axial themes for the core variables that characterized the phenomenon (Glaser & Strauss, 1967). The core variables that emerged from the axial themes included: (a) inactivity as a result of delayed authorization to work, (b) disappointment of the expectations that motivated immigration, (c) financial dependency on hosts, (d) unmet material and social needs, and (e) relying on risky behaviors for socialization. Thus, the core variables that emerged during selective coding to answer research question 1 may be formulated in the following way: susceptibilities that predispose Sub-Saharan male African immigrants to high-risk

sexual behaviors when they come to the United States include inactivity, disappointed expectations, financial dependency, unmet needs, and reliance on risky behaviors for socialization. Results related to research question 2 indicated cultural factors that may also contribute to susceptibility in this population.

Research question 2. Research question 2 was: What are the perceived cultural safeguards (cultural, social, and economic) that existed in Africa that are absent in the U.S. and has exposed African-born U.S. residents to HIV? Interview question #6, 7, 9,10,11, 12, 13, 14,15, and 16 were appropriated to extract thematic responses to provide feedback to research question 2. The presentation of results related to this research question is organized by the axial codes or themes that emerged during data analysis. Within the presentation related to each axial code, the discussion indicates the open codes that were grouped into the axial code. Discussion of the selective coding phase is provided at the end of the presentation related to research question 2, as a comprehensive summary of the results and an answer to the research question.

Axial code 5: Higher awareness of HIV risk in Africa. Fourteen out of 14 participants stated that cultural safeguards against HIV infection that exist in Africa but are absent in the United States include a higher awareness of HIV risk. Participants stated that the risk of HIV infection is frequently advertised and discussed in Africa and that this causes men to engage in fewer high-risk behaviors. The lower prominence of HIV risk as a topic of public discussion in the United States, however, may allow some male African immigrants to believe that there is no risk and that they can engage in high-risk behaviors with impunity. Table 11 indicates the open codes that were grouped into this

axial code. Quotations from the data are then provided as evidence for the open codes and axial code.

Table 11

Open Codes Contributing to Axial Code 5

Open Code (OC)	Participants contributing to open code
OC 18 Less fear of HIV leads to less condom use in U.S.	1EP, 2SP, 3TP, 4LP, 5KD, 6EN, 7SP, 8 KD, 9ND, 10SP, 11KD, 12NP, 13CD, 14ZD
OC 19 More fear of HIV in Africa leads to more condom use.	1EP, 2SP, 3TP, 4LP, 5KD, 6EN, 7SP, 8KD, 9ND, 10SP,11KD, 12NP, 13CD, 14ZD
OC 20 Does U.S.A has more Education publications HIV risk warning than Africa?	5KD, 8KD, 9ND, 14ZD
OC 20 Does Africa has more HIV Education publication than USA	1EP, 2SP, 3SP, 4LP, 6EN, 7SP, 10SP,11KD, 13CD, 14ZD

Note: Participants (N = 14) Subjects could provide more than one answer

Table 12 Numeric Computation

Open Codes Contributing to Axial Code 5

Open Code (OC)	No. of Responses	% of Participants
OC 18 Less fear of HIV leads to less condom use in U.S.	14	100%
OC 19 More fear of HIV in Africa leads to more condom use.	14	100%
OC 20 Does U.S.A has more Education publications of HIV risk warning than Africa?	4	29%
OC 20 Does Africa has more HIV Education publication than USA	10	71%

Note: Participants (N = 14) Subjects could provide more than one answer

Open code 18: Less fear of HIV leads to less condom use in U.S. Fourteen out of 14 participants indicated that African men are less afraid of HIV infection in the United States than they are in Africa, and that lowered vigilance allows them to engage in high-risk behaviors. 1EP stated, “African immigrants don’t use condoms in America, want bare sex. They may use a condom in Africa because they are scared of infection.” 3TP indicated that some male African immigrants may believe HIV does not exist in the United States: “African immigrants do not wear condoms in USA because they think in USA women do not have HIV. This exposes them to contracting the disease.” 6EN agreed, stating, “They contract the disease in America due to lack of condom usage. In Africa they are scared of contracting the disease so they use condoms.” 11KD expressed

the same perception as 3TP, that male African immigrants may believe U.S. women are disease-free: “African immigrants when they arrive in USA engage in unsafe sex with the thinking that American women have no disease.”

Open code 19: More fear of HIV in Africa. fourteen out of 14 participants spoke specifically of the effect that heightened awareness and fear of HIV infection had on African males while they were in Africa. Open code 19 was closely related to open code 18, which included data indicating the lowered vigilance of male African immigrants residing in the United States. In results associated with open code 19, participants spoke directly of the heightened vigilance of African males residing in or visiting Africa. 3TP stated, “African immigrants cannot contract a disease when on holiday in Africa because they are scared of contracting a disease knowing that HIV is everywhere.” 9ND spoke in similar terms, stating, “African immigrants have [the] highest risk of contracting a disease in the USA. Immigrants are scared to have sex in Africa because they know they will contract the disease.” 10SP also spoke of the heightened awareness of HIV risk in Africa as promoting more caution or even abstinence: “when [African-born males] go to Africa they are scared to have sex, with the assumption that every woman might be infected.”

Open code 20: More education and publicity on HIV risk in Africa. Four out of 14 participants indicated that the reason for the heightened awareness of HIV risk in Africa was the high volume of publicity and public discussion devoted to the danger of infection there and the comparative lack of such publicity in the United States. 5KD spoke of frequent radio advertisements in Africa: “African immigrants contract HIV by having

unsafe sex in USA because in America there is no advertisement against in unsafe sex compared to Africa. In Africa every radio station announces about unsafe sex because of HIV." 8KD spoke of public discussions in the workplace:

> [African males] contract the disease in the United States. I worked in Africa; companies held weekly meetings about HIV. Since coming to the United States, my company does not talk about HIV. Since people are unaware, they think there is no HIV in America and contract the disease. (8KD)

14ZD expressed the perception that the lack of publicity in the United States causes male African immigrants to think the disease is not a threat in their host country; he also recommended that educational efforts be undertaken to warn incoming immigrants about the danger:

> Immigrant people are not very educated about HIV. They are not told about the danger of contracting the disease when they come to America. They should be told before they come by the embassies or immigration officers before they immigrate. Therefore, they contract HIV in U.S. because they are unaware. (14ZD)

Axial code 6: High-risk sexual behaviors are less accessible in Africa. Ten out of 14 participants stated that cultural safeguards against HIV infection that exist in Africa but are absent in the United States include the lower accessibility of high-risk behaviors. Participants stated that prostitutes are easier to engage in the United States, that people are generally less accountable for their sexual behaviors in the U.S., and that it is easier in the U.S. to have sex with multiple partners. Table 13 indicates the open codes that were

grouped into this axial code. Quotations from the data are then provided as evidence for the open codes and axial code.

Table 13

Open Codes Contributing to Axial Code 6

Open Code (OC)	Participants contributing to open code
OC 21 Prostitutes are easier to find in the U.S.	2SP, 4LP, 7SP, 11KD, 13CD, 14ZD, 3TP, 9ND, 8KD
OC 21 Prostitutes are easier to find in Africa	5KD, 6EN, 3TP, 10SP, 12NP, 1EP
OC 22 Less sexual accountability in the U.S.	2SP, 3TP, 4LP, 7SP
OC 22 More sexual accountability in Africa.	1EP, 5KD, 6EN, 8KD, 9ND, 10SP,11KD, 12NP 13CD, 14ZD
OC 23 Easier to have multiple partners in the U.S.	2SP, 3TP, 4LP, 5KD, 6EN, 7SP, 10SP, 11KD, 12NP, 14ZD
OC 23 Easier to have multiple partners in Africa	1EP, 8KD, 9ND, 13CD
OC 24 Contract HIV in Africa	12NP, 1EP
OC 25 Contract HIV in USA	2SP,3TP, 4LP, 5KD, 6EN, 7SP, 8KD, 9ND, 10SP, 11KD, 13CD, 14 ZD

Note: Participants (N = 14) Subjects could provide more than one answer

Table 14 in Numerical Computation

Open Codes Contributing to Axial Code 6

Open Code (OC)	No. of Participants Response	% of Participants
OC 21 Prostitutes are easier to find in the U.S.	9	64%
OC 21 Prostitutes are easier to find in Africa	6	42%
OC 22 Less sexual accountability in the U.S.	4	28%
OC 22 More sexual accountability in Africa	10	71%
OC 23 Easier to have multiple partners in the U.S.	10	71
OC 23 Easier to have multiple partners in Africa	4	28%
OC 24 Contract HIV in Africa	2	14%
OC 25 Contract HIV in USA	12	86%

Note: Participants (N = 14) Subjects could provide more than one answer

Open code 21: Prostitutes are easier to find in the U.S.

Participants 2SP, 4LP, 7SP, 11KD, 13CD, 14ZD, 3TP, 8KD and 9ND stated that prostitutes were easier to find in the United States than in Africa and that this condition led African males to engage in more high-risk behaviors in the United States. 2SP stated that “advertisements for escort services were commonplace in U.S. media: Easier to find a partner in USA for the night than in Africa. In America they always advertise on TV and phone numbers are right there on the screen.” 4LP also referred to the perceived ubiquity of prostitutes’ advertisements in the United States: “Easier to have night partner

in USA due to TV ads with phone numbers. In most African countries it would be a taboo to advertise sex publicly on TV." 13CD expressed that obtaining the services of a prostitute was, "Easier in USA due to high level of publicity for sex for money and TV ads."

On the other spectrum, 5KD, 6EN, 9ND, 10SP, 12NP participants mentioned that depending where you are in Africa prostitutes can be easier to find than in US due to poverty and cheaper. 5KD noted "In my former African country some business leaders in the cities are investing into prostitution making it easier to find a woman for night." 6EN and 1EP insisted "It was easier to find a woman for the night in Africa because of poverty and it was cheaper than in the US." Participants 12NP added "the sensual western life style that existed in western countries and related businesses of prostitution are being duplicated in cities in his former country."

Open code 22: Less sexual accountability in the U.S.

Participants 2SP, 3TP, 4LP, 7SP indicated that accountability for sexual behaviors is present in Africa but absent in the United States, and that this allows African-born males to engage in riskier behaviors after they have immigrated. 3TP referred to several cultural safeguards that contributed to African males' sense of accountability when they were in Africa: "[African-born males] contract the disease in the United States where they are free of religion, family accountability and cultural freedom. They think they have reached the top of the world where they can do anything without accountability." 4LP said of African-born males, "They can contract disease very minimally in Africa but largely here in the United States because they are free from behavioral accountability [here]." 7SP

referred specifically to sexual accountability associated with religion in Africa: “African immigrants, especially Muslims, don’t have sex in Africa for fear of being stoned. However, when these men come to USA they feel liberated and can have sex with anybody they want without fear of retribution.”

Open code 23: Easier to have multiple partners in the U.S.

Participants 2SP, 3TP, 4LP, 5KD, 7SP, 10SP, 11KD, 14ZD, indicated that it was easier in the United States than in Africa to engage in the high-risk behavior of having sex with multiple partners. 8KD stated, “African immigrants contract HIV in USA by having multiple partners.” 3TP related the risk of HIV infection in the United States to the ease of travel: “It is easy to have multiple sexual partners in America in various cities and states. No one knows that you have multiple partners in different cities compared to Africa where it is difficult to travel from city to city.”

Open code 23: Easier to have multiple partners in Africa.

The general assumption to this theme was that normality of polygamy culture gives men misogynistic perception to engage in extramarital sexual relationships. Participants 1EP, 6EN , 10SP, 5KD supported the idea that it was easier to have multiple partners in USA than in Africa. 1EP went further by stating that “It is easier to have multiple partners in Africa due to cultural acceptance of polygamy, therefore having casual girlfriends is a tolerable behavior.” 9ND added “In my former country in Moslem communities having a girlfriend was not acceptable and if a relationship exposed both partners can be stoned. Marriage is the only option of having multiple partners.” 8KD mentioned “Due to poverty and a culture that is male dominated and favors male, men can easily monopolize

on having many girl-friends." 13CD related a story in which he said "One of my old friends in Africa had 5 girlfriends by pretending that he was going to marry them and the girls fell for it and he ended up having sex with all of them and never married them.

Open code 24: Do you think you think people contract HIV in Africa?

The open code 24 was generated in semi-structure question 16 with the goal of asking participants to deduce of what place they thought African born immigrants contract HIV. Participant 1EP mentioned that "They contract HIV in Africa because in United States HIV was not as rampant as Africa." In addition, 14ZD noted that:

> First generation immigrants cannot come with the diseases from Africa due to increased awareness and American embassies in third world countries still send first travelers to US to be screened for diseases and those who are positive for any disease are not permitted to travel. Therefore, African immigrants who come to the United States who do not come with the disease from Africa, consequently, if they have disease, they must have contracted disease here in the United States.

Open code 25: Do you think people contract HIV in U.S.A.

12 out 14 participants noted that African immigrants who did not come with the disease when they migrated to the United States must have contracted the disease in the United State and not Africa. Participant 3TP mentioned that "Due to lack of cultural barriers, traditional values, lack of family accountability, easy access to phone sex and brothel houses, African immigrants found it easier to expose themselves to sexual risk-taking behavior". 13CD respectively noted that:

> Since I came from a conservative religious country in which women are forced to

> wear clothes from head to toe, in-fact most us men never had a chance to see a woman to see wearing a tight dress and see the shape of breast and women buttocks it is very exciting to see all that when I came to the U.S. and that enticements resulted into promiscuity. (13CD)
>
> I was brought up in the environment in which I had never seen a woman legs, thighs, arms and buttocks and until when I came to the U.S.A, in-fact to be instantaneously be exposed to a woman wearing shots and sports-bra was more than enticing and my friends have fallen in the same trap of lust and sexuality resulting into having multiple sexual partners (2SP).

Selective coding. Selective coding involved analyzing the axial themes for the core variables that characterized the phenomenon (Glaser & Strauss, 1967). The core variables that emerged from the axial themes to answer research question 2 included: (a) the risk of HIV infection is more prominently publicized and discussed in Africa than in the U.S., (b) there is higher awareness of HIV risk in Africa, and (c) high-risk sexual behaviors such as prostitution and multiple partners are less available and more condemned in Africa. Thus, the core variables that emerged during selective coding to answer Research Question 2 may be formulated in the following way: Cultural safeguards that existed in Africa but are absent in the U.S. include more prominent discussion and publicity of HIV risk, heightened awareness of HIV risk, and the condemnation and associated rarity of high-risk sexual behaviors.

Research Question 3. Research Question 3 was: What does the African immigrant male perceive to be dissonant in the U.S. culture that promoted risk-taking behavior? Cultural dissonance is an uncomfortable sense of discord, disharmony, confusion, or conflict experienced by people in the midst of change in their cultural environment. The presentation of results related to this research question is organized by the axial codes or themes that emerged during data analysis. Discussion of the selective coding phase is provided at the end of the presentation related to research question 2, as a comprehensive summary of the results and an answer to the research question.

Axial code 7: The dissonance of equal rights for U.S. women. Utilizing interview question # 8 to extract responses to answer research question #3. All participants indicated that they had experienced a sense of cultural dissonance when they encountered the comparative legal and social equality of men and women in the United States. Participants perceived women in Africa as submissive to men's leadership, and they perceived women's submissiveness as placing the responsibility for most matters firmly with the husband and thereby reducing discord in the home. The comparative equality of U.S. women was perceived as absolving men of the duties of initiative and family leadership, weakening the marriage bond, and undermining men's characters. Participants saw these factors as promoting high-risk sexual behaviors in the United States because of increased discord in the home, including promiscuity. Participants' responses in relation to the dissonance of U.S. women's equality were sufficiently unanimous that they were all grouped into a single open code during first-cycle coding, but they remained sufficiently distinct from other themes that the open code was renamed

and made into an axial theme during the second cycle of coding without addition or subtraction of data.

Table 15

Open Codes Contributing to Axial Code 7

Open Code (OC)	Participants contributing to open code
OC 26 In Africa, mostly men propose for marriage and become head of household	1EP, 2SP, 3TP, 4LP, 5KD, 6EN, 7SP, 8KD, 9ND, 10SP, 11KD, 12NP, 13CD, 14ZD
OC 27 In America either males or females can propose and either can become the head of household	1EP, 2SP, 3TP, 4LP, 5KD, 6EN, 7SP, 8KD, 9ND, 10SP, 11KD, 12NP, 13CD, 14ZD.

Note: Participants (N = 14) Subjects could provide more than one answer

Table 16 in Numerical Computation

Open Codes Contributing to Axial Code 7

Open Code (OC)	No. of Participants response	% of Participants
OC 28 In Africa, mostly men propose for marriage and became head of household	14	100%
OC 29 In America either males or females can propose and either can become the head of household	14	100%

Note: Participants (N = 14) Subjects could provide more than one answer

Open code 28-29: Women's equal rights a challenge for African immigrants.

Open code 28-29 was generated from interview question #8. 1EP described the cultural dissonance he had perceived in the following representative response:

> In Africa male and female relationship is not mutual. Females are submissive, loyal and respectful to men compared to America. In America women are equal to men and relationship can be very difficult because no one is leader in the house or relationship. (1EP)

2SP specifically linked women's rights to a man's sense of responsibility:

> American women are indoctrinated with equal rights with men. Equal rights give women power, extending that power into the house and weakening man's responsibility and authority. As a result, American men became weak and not able to assume risk to protect family. In Africa because of women's submission to man, men take risk at all cost to protect the women and the children. (2SP)

4LP linked women's rights to men's lowered feeling of responsibility and "running away":

> In America the male and female relationship is equal. In America men have been weakened and fear to take responsibility and let the woman control a man and the house. Therefore, men can easily run away from the house because they don't feel responsible and also feel the woman can equally take care of it. In Africa, because women are submissive to man, the man can't run away from the house because he feels he is the custodian of the house. (4LP)

7SP used language similar to 4LP's in speaking of men's "running away" as a result of their diminished feelings of responsibility: "The man does not feel responsible for the woman and nobody is a leader. Therefore, this shared sexual relationship of equal rights makes the man weak and can easily run away from it without accounting for his responsibility." 8KD spoke of a diminished sense of responsibility specifically toward one's wife as a result of the perception that she could act for herself: "In America equal rights makes both parties responsible for marriage. However, I feel this has weakened American men and do not feel responsible to take care of the woman thinking she can take care of herself."

Axial code 8: The dissonance of increased working hours. Fourteen out of 14 participants reported that their work schedules in Africa had been relatively undemanding, but that in the United States they found themselves compelled to engage in paid work during almost all of their waking hours just to earn a subsistence. Participants found the necessity for constant work and the corresponding lack of leisure time taxing and demoralizing, and they suggested that these conditions may cause some African-born males to overcompensate by engaging in irresponsible sexual behaviors while in the United States. As with axial code 7, participants' responses in relation to the dissonance of increased working hours were sufficiently unanimous that they were all grouped into a single open code during first-cycle coding, with the open code being renamed and made into an axial theme during the second cycle of coding without addition or subtraction of data.

Table 17

Open Codes Contributing to Axial Code 8

Open Code (OC)	Participants contributing to open code
OC 30 Longer working hours in the US than Africa	1EP, 2SP, 3TP, 4LP, 5KD, 6EN, 7SP, 8KD, 9ND, 10SP, 11KD, 12NP, 13CD, 14ZD
OC 30 Longer working hours in Africa than US	None responded

Note: Participants (N = 14) Subjects could provide more than one answer

Table 18 in Numerical Computation

Open Codes Contributing to Axial Code 8

Open Code (OC)	No. of Participants Response	% of Participants
OC 30 Longer working hours in the US than Africa	14	100%
OC 30 Longer working hours in Africa than US		None responded

Note: Participants (N = 14) Subjects could provide more than one answer

Open code 30: Constant work in U.S. to survive. 14ZD described his experience of the contrast between working conditions in Africa and the United States as follows:

> Since arriving in the USA, it is all work, work, work to survive. It is difficult to visit friends and family without appointment. In Africa not everything is money and I went to work with no pressure to survive. In Africa I worked only 8 hours and no overtime … All I do [in the U.S.] is work, sleep and pay bills. (14ZD)

5KD described the effects of increased working hours on his social life:

> "In Africa I and my friends after work we would go to a bar and have couple beers. I visited my uncles, aunties and friends with no appointments. Since coming to America, I have to make appointments before visiting them at home. In America I work hard to survive – more than I did in Africa. In America I do socialize by going gambling at casinos, I go to a bar once in a while." (5KD)

6EN described the same experience of dissonance: "In Africa just working 8 hours was enough to live comfortably. In America I have to work overtime to survive." 13CD described Africa as more fun because there were fewer demands on his time: "In Africa my routines were more fun because there was no limitation on time … The difference between Africa and America I have seen is that in America must do everything to survive because of financial demands." 14ZD used vivid language in describing his sense of dissonance:

> Most of my early life in America involved working overtime like a dying person. In Africa my routine was casual, no pressure, just living life and relaxed. In Africa I had a girlfriend I spent most of the time with. I worked part-time and performed house chores at my parents' residence. I had no worries in Africa; but in America to survive was like hell broke loose. (14ZD)

Selective coding. Selective coding involved analyzing the axial themes for the core variables that characterized the phenomenon (Glaser & Strauss, 1967). The core variables that emerged from the axial themes to answer research question 3 included: (1) the dissonance of U.S. women's equal rights, and (2) the dissonance of increased working hours. Thus, the core variables that emerged during selective coding to answer research question 3 may be formulated in the following way: perceived cultural dissonances that may promote risk-taking behavior among African-born males living in the United States include the comparative legal and social equality of U.S. women and men, and the necessity of working an increased number of hours in the U.S. to earn a subsistence.

Summary

The purpose of this grounded theory study was to explore the factors that may predispose first-generation Sub-Saharan African-born men living in the United States to risky sexual behaviors that may place them at risk of becoming HIV infected. To achieve this, one-on-one, semi-structured interviews were conducted with 14 African-born men who self-identified as having come from Sub-Saharan African countries and who were residing in the United States at time of the study. Results indicated that susceptibilities predisposing male Sub-Saharan African immigrants to high-risk sexual behaviors when they come to the United States include inactivity, disappointed expectations, financial dependency, unmet needs, and reliance on risky behaviors for socialization. In addition, results indicated that cultural safeguards that existed in Africa but are absent in the U.S. include more prominent discussion and publicity of HIV risk, heightened awareness of HIV risk, and the condemnation and associated rarity of high-risk sexual behaviors.

Lastly, results indicated that perceived cultural dissonances that may promote risk-taking behavior include the comparative legal and social equality of U.S. women and men, and the necessity of working an increased number of hours in the U.S. to earn a subsistence. Chapter 5 includes discussion, interpretation, and implications of these results, including preliminary steps toward generating the grounded theory model development.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

In this study thematic categorization was performed to generate data analysis. Research participants' responses were gathered and utilized to generate codes, concepts, and categories. Codes offered the study the ability to identify themes and key points of the data to be gathered. Similar codes were grouped together to form constructs. These constructs were defined as concepts which are a collection of codes of analogous contents that allowed the data to be grouped. Similar constructs were grouped to form categories. Grouped categories were supposed to be utilized to generate grounded theory, however, grounded theory could not be generated because the perspective participants were not available to be interviewed for the second and third time to create responses necessary to generate constructs for synthesis of grounded theory.

There were 14 research participants that were first-generation Sub-Saharan African U.S. immigrant residents. The Sub-Saharan research participants' countries of origin ranged from Zambia, Tanzania, Kenya, Nigeria, Ethiopia, Cameroon, Liberia, Sierra Leone, and Sudan. Each research question had participants' responses which were coded into a thematic code. Utilizing NVivo research instrument, thematic codes were then compared to generate similar constructs which serve as categorical study findings. The discovered study findings could be utilized in developing culturally appropriate HIV health education strategies among Sub-Saharan African born male U.S residents. This phenomenological study employed the HBM to interpret findings and grounded theory

for data analysis. This chapter consists of interpretation of the findings, limitations of the study, discussion and implications for social change.

Interpretation of Findings

The first research question asked to explain the life experience after the participants had just arrived in the United States as an immigrant. Based on HBM this question served to generate an understanding of the Sub-Saharan immigrant feeling of loss and emptiness related to the lack of proper socialization by the host family. The host family consisted of extended family members or one respondent related that his host was a friend of the family. Despite the fact that they were completely dependent financially of the host, some respondents did not feel that they were adequately cared for as they lacked money for transport, food, and toiletries. From the respondent's perception, some host families did not include them in their social outings or even spend time after work to get to know them. Secondly, the lack of socialization led to long periods of being alone and boredom as many awaited three or more months to attain their social security card which was required prior to obtaining a job. Third, the difference in cultural values seemed overwhelming to most respondents as the social mores regarding sexual behavior and dress were different than their home country. This freedom, according to some of the respondents, encouraged them to think that the American women were healthy and therefore they did not need to have protected sex with American women. In addition, the role of the male in the household was changed in the American environment as either the man or woman could be the head of the household. The respondents related that this brought instability to the home. Furthermore, the acceptance of polygamy in Africa has

been translated into American culture among Sub-Saharan Africans by their unspoken belief that having multiple sexual partners is acceptable.

This study in axial theme one found that inactivity, disappointment of expectations that motivated the individual to migrate, financial dependency, unmet material and social needs and relying on risky behaviors for socialization thrusted the study participants towards activities that put themselves at risk. Chaumba, J. (2016) mirrored this finding that inactivity and financial dependency impaired their ability to adapt to the new environment.

Like Rosenthal et al. (2003) who noted that there was an increase level of knowledge of HIV and a decrease use of condoms and perception of risk, this study also found that Sub-Saharan African males. Similarly, this study identified in axial theme two that the rampant publicity surrounding HIV prevention that exists in Africa acts as a deterrent and increases awareness about the danger of risk-taking behavior. Subsequently, when the Sub-Saharan African male arrives in the United States and rarely hears about HIV risk, there is a false perception of the prevalence of HIV disease in America.

According to Afulani and Asunka (2015) legal and social equality of U.S. women and men, as found in this study as the third axial code, creates cultural dissonance thereby placing the traditional values of male head of household in conflict with what they experience in America. Secondly, the dream of the immigrant coming to the United States to become wealthy is quickly squelched as they find themselves working increased hours just to earn a subsistence living. This finding does not give direction as to what in the culture promotes sexual risk-taking behavior.

Research Question 1: Explain your life experience after you had just arrived in the United States as an immigrant.

Research Question 3: What were your financial survival experiences?

The goal of Research Question 1 was to analyze the pathways of Sub-Saharan African born immigrants after arrival in the United States that may expose them to HIV. The goal of Q3 was to generate themes to understand their financial capability in relation to attitudes of sexual behavior in their initial stages of arrival.

In the first question participants had varied responses: 5 of 14 (36%) noted that being bored and had nothing to do as they waited for immigration papers to be processed for residence and work permit. 9 out of 14 (64%) participated in home chores. 4 out 14 (29%) felt disappointed with the immigration process and indicated they felt incapacitated while waiting for permits to work. 3 out 14 (21%) had difficult speaking English though they could understand the spoken language they could not express themselves. 11 out 14 (78%) noted that they spoke English proficiently even though they had African accent compared to American accent. Rivers (2012) and Chaumba (2016) both identified that the adaptation of the African to the new environment was hampered by their ability to obtain documents for work, such as social security card and green card. Coupled with the struggles to become acclimated with the social environment of the United States thereby hindered their acclimation to the society.

The goal of Q 3 was to analyze their financial stability. 2 out of 14 (14%) ended up fasting or intentionally not eating because they could not afford 3 meals per day. Morrison, Haldeman, Sudha, Gruber, & Bailey, (2007) identified that the lack of familiar

foods diminished the nutritional intake of the immigrants thereby resulting in hunger and weight loss. 12 out of 14 (86%) revealed that they experienced food deficiencies. One participant noted that he arrived with nothing from Africa except with clothes on his body. 13 participants expressed having arrived with very little money and few clothing on themselves. Study findings based on thematic open codes on life experiences of first Sub-Saharan African born US residents suggest that this population encounter: dependence, communication barriers, near homelessness, poverty and financial constraints. Afulani, & Asunka, (2015) also identified that African immigrants were affected by lack of financial support thereby hindering their ability to become self-reliant.

Q2. After arriving in the United States what were the daily routine experiences you began to perform?

The goal of Q2 was to analyze activities and habits that may predispose African immigrants to HIV in the initial stages of their arrival. Responding to the question, 14 of 14 participants noted that the delay in the immigration process and work permit prolonged their dependence and reliance on the host family. Covington-Ward, (2017) identified that post-immigration adjustments for Liberians in Pittsburgh created challenges to that would prohibit adjustment to American society. 10 out 14 (72%) noted that they lacked adequate transport for interviews, for church and to go to immigration assessments for residence. 4 out of 14 (29%) noted that they completely depended on the host family for transportation since did not have any money for taxi or bus and did not know the environmental terrain of their neighborhood. Participants expressed that they

watched a lot of television, performed house chores and experienced severe boredom. Study findings indicated that the study participants daily routine during their initial stages of their arrival preclude them to be dependent, have transportation difficulties, perform house chores and watch a lot of television. Konadu-Agyemang, (1999) also identified the progressive experiences of Ghanian migrants in Canada as they acclimated to their new environment. They also experienced similar frustrations.

Q 4. What was your social support group and how did they provide for your needs?
Q5. What were the strengths and weaknesses of support group or friends you noticed?

The purpose of Q4 was evaluate the network of social support in relation to risk taking behavior during the initial stages of arrival. 9 out of 14 (64%) participants lacked socialization and mostly stayed at home. 5 out 14 (35%) indicated minimal socialization such as going to church and accompanying host family to see their friends. Only one participant indicated that they liked American food. 13 out 14 (93%) of participants did not like American food. 13 out 14 (93%) did not receive any guidance of how to adapt living in America. The social support network for participants after their arrival in the US consisted of new-found friends, and distant relatives. The goal of Q5 was to ascertain the strengths and weaknesses of their social group. The strength of social support or host family was that they helped the participant survive and acclimatize to US culture and environment. The identified weaknesses of the participants social support included: lack of socialization, financial constraints, decreased support and interaction with participants. Study findings that emerged from Q4 and Q5 include: the lack of socialization, lack of

orientation to U.S culture, non-cohesive relationship with host family and decreased interaction and support from the host family. Likewise, Afulani, & Asunka, (2015) examined the effect of socialization and transnationalism and found that the strong social support improved the acculturation and assimilation.

Q 6. For socialization, what are some places you frequented or activities you involved yourself?

Q 7. What are cultural norms of sexual behavior you had in your home country and how have they differed between your home country and United States?

The goal of Q6 was to track the Sub-Sahara African born immigrants sexual risk-taking behavior after they had established themselves in the US. 14 out of 14 (100%) of participants indicated that they socialized where sexual partners would be available. 14 out of 14 (100%) of participants stated that they preferred not to use a condom during intercourse. 11 out of 14 (79%) of participants enjoyed unprotected sex - even if they engaged in having sex with multiple partners. 3 out 14 (21%) noted that they used a condom if they engaged in sex with multiple partners. Study findings and themes that arose from Q6 and Q7 included: socialization in places where sexual partners could be found such as wedding, bars, strip clubs, African Association groups and funerals. 14 out of 14 (100%) stated that heterosexual relationships were found to be preferred to homosexual among participants. These study findings are similar to that of Kwakwa, Doggett, Ubaldi-Rosen, McLellan, Gaye, et al. (2012) and Blanas, Nichols, Bekele, Lugg, Kerani, & Horowitz, R. (2013) in that African immigrant sexual tendency is that of

heterosexual. This study accentuates the finding the premises that risk taking behavior may take place as a result increasing the risk of contracting HIV in the population.

Q 8. What's your views toward women/men in the United States compared with your view of women and men in your home country?

The objective of Q8 was to discover the Sub-Saharan African born US residents attitude and culturally perceived beliefs towards women. The study found that 14 out of 14 participants (100%) believed that the man should be the head of the house, the man should first propose to a woman for friendship or marriage, and be able to take responsibility to divorce the woman. Again 100% or 14 participants felt mystified that in the United States women have power sharing in the household leadership because of equal rights. Like the findings in Musyoka (2014), the phenomenological study finding themes for this question indicate that Sub-Saharan African born U.S. residents come from patriarchal society with the cultural belief of being the head of the household. The patriarchal view may molt into misogynistic behavior in which men dominate and control the rhythm of man/woman relationship. Women and men have equal power in the household in the US was another perception of Sub-Sahara African born US resident. The equality of men and women in the relationship was rebuffed as a weak link in the household dynamics that may predispose marriage to increased rate of divorce.

Q 9. What kind of sexual relationship do you prefer, with men or with women?

The purpose of question 9 was to seek to understand the sexual orientation of Sub-Sahara African born immigrants and whether they indulge in homosexual or heterosexual relationships. 14 out of 14 (100%) participants noted that the heterosexual relationship was the only type of sexual relationship in which they would engage. They also related that in their perception that there is no disease to be transmitted in the American heterosexual or homosexual relationship. These study findings are similar to that of Kwakwa, Doggett, Ubaldi-Rosen, McLellan, Gaye, et al. (2012) and Blanas, Nichols, Bekele, Lugg, Kerani, & Horowitz, R. (2013) in that African immigrant sexual tendency is that of heterosexual.

Q 10. What are differences between the sexual relationships you had in the United States and your home country? Do you think it would be easier to find a sexual partner for a night in the United States or Africa?

This question (Q10) was asked to identify the sexual risk-taking behavior tendencies among Sub-Sahara African males. Responses from the participants in the open-coded response showed that 57% said it was easier to get prostitutes in the United States than in Africa while 6 out of 14 (43%) thought it was easier to find a prostitute in Africa. Secondly, 10 out of 14 (72%) of the participants identified that the societal pressure to limit their risk-taking behavior that exists in Africa is not existent in the United States. Four out of four participants (28%) felt they still had self-restraint and limited their sexual risk behavior. Again, 10 out of 14 (72%) identified that it was easier

to have multiple partners in the United States while four out of four (28%) felt it was easier in Africa. This study gathered the grass root of knowledge related to ease of a Sub-Saharan obtaining a prostitute in America compared to their home country. Kwakwa et al. (2012) looked at transmission of heterosexual HIV in this population but did not report the comparative ease of obtaining a prostitute in America versus Africa. Castillo-Mancilla, & Carten, (2010), identified the need to devise a registry for the sero-type HIV in foreign-born people to determine the origin of the strain of HIV.

Q 11. In your opinion, how do you think African immigrants contract HIV?

This question (Q11) was asked to determine the comprehension of the causes and awareness of effect of HIV on the individual. 100% of participants indicated that unprotected sex and multiple sexual partners was the major cause of HIV in their population. Connor, Lund, Ciesinski, Finsaas, & Bichanga, (2016) and looked at an HIV prevention model and noted that multiple sexual partners was an underlying cause of HIV transmission in the African community. Kwakwa, et al. (2012) and Koku, Rajab-Gyagenda, Korto, Morrison, Beyene, et al. (2016) identified that African immigrants have multiple sexual partners and partake sexual risk taking behaviors.

Q 12. In your opinion do you think that African immigrants have a higher risk of contracting HIV when they go back to Africa on holiday? Or do you think they have a higher risk of contracting HIV in the US?

This question sought to ascertain whether the participants thought that there was a greater propensity to contract HIV in the United States compared to Africa. 11 out of 14 (79%) of the participants responded that they thought they contract HIV while in United States not in Africa due to diminished cultural inhibitions. Furthermore, two out of 14 (14%) thought they contract HIV while in Africa on holiday and 7% (1) thought they could contract HIV in Africa and the United States. Sides. Ogunjimi, (2017) found that the transmission rate of HIV among African immigrants was higher in the United States because of the lack of condom use.

Q 13 What symptoms do you think the African-born immigrant would begin to recognize that he has contracted HIV infection?

Generated themes from this question included weight loss, fever, tuberculosis, and skin rashes. However, 100% of participants identified weight loss as the main symptom and two out of 14 (14%) identified fever as a symptom. This indicates that the Sub-Saharan African males are aware of the HIV symptoms. Kwakwa et al. (2012) and Blanas (2013) discovered that African born immigrants have general knowledge of the symptoms of HIV infection. Amadi (2012) found that when analyzing the perceptions and attitudes of HIV among Sub-Saharan Africans that they understood the signs and symptoms of the disease.

Q 14 What social behavioral activities do you think expose African-born immigrants to contracting HIV?

The generated themes for this question included sex without a condom, alcohol consumption, African late-night parties, attending red light district/strip clubs and bars. 36% (5/14) of participants stated that night clubs while 36% stated that alcohol consumption played a role in decreasing their inhibition to sexual risk taking. 21% (3/14) identified that attending African parties contributed to the exposure to HIV. These responses indicated that the participants felt that there was a mixture of points of exposure to HIV. The study findings of Sofolahan-Oladeinde, Iwelunmor, Tshiswaka, & Conserve, (2014). Kerani, (2017) and Ogungbade, (2010) found that African born immigrants attending strip clubs, African parties, and funerals partake in sexual risk-taking behaviors that may expose them to HIV.

Q 15 Thinking about your African friends, do you think their fear of contracting HIV while living in the United States has affected their attitude towards use of condoms?

14/14 (100%) stated that they would not use a condom in the United States. 14/14 (100%) also related that if they were to have sex in Africa, they would use a condom. The participants verbalized that they felt American women were healthy and they did not need to use a condom compared to Africa where they stated that they felt that most women had HIV. Ebrahim, Davis, & Tomaka, (2016) found that their knowledge of HIV transmission did not influence their decision to use or not use the condom. Ogungbade, (2010) also noted that Sub-Saharan Africans tend not to use condoms during sexual relationships.

Q 16 Is there something else that you would like to add about factors that could potentially expose the African-born immigrants to HIV in the United States?

This question was asked to ascertain the additional risk factors that may not have been discussed during the investigators interview. 12/14 (86%) participants verbalized their perception that HIV is highly contracted in the United States because there is no publicity about the disease compared to Africa while 2/14 (14%) identified that HIV cannot be contracted in Africa because HIV infection is highly publicized. They stated that in the USA there is a lack of HIV/condom publicity compared to Africa where there is a high level of publicity on the need to use a condom on every radio station. This level of social communication was perceived to be an inhibitor of sexual risk-taking behavior. Wiewel, Torian, Hanna, Bocour, and Shepard, (2015) discovered that the acquisition of HIV among Africans was from outside the United States.

Health Belief Model as a Modifying Factor

The theoretical model that was utilized to guide this study in the prevention of disease among Sub-Saharan Africans is the HBM. This theory encompasses modifying three factors and these include perceived benefit, barrier and susceptibility.

Perceived Benefits of HBM

Janz and Becker (1984), in their publication on HBM research, mentioned that perceived benefits infer to the person's assessment of the efficacy of involvement in a health prevention behavior in order to minimize the risk of disease. This means that if the person perceives that a specific action will decrease susceptibility to the health disease severity, that individual will engage in that behavior modification.

In this study, the risk outweighs the benefit. The Sub-Saharan African males perceived that HIV is contracted in America more than Africa because the multimedia campaigns that exist in Africa to explain the spread of HIV and the importance of having safe sex is not found in America. This perception is paramount to the future of public health campaigns in the prevention of HIV transmission in America.

Perceived Barriers

In their published research on health behavior on health education, Glanz, Rimer, and Viswanath (2008) noted that perceived barriers refer to obstacles assessed by the individual as hindrances to behavior change. Barriers prevent involvement in health prevention behavior. In this study, 12 of the 14 participants noted that lack of condom availability in every shop has presented as a barrier to the prevention of HIV among Sub-Saharan African immigrant compared to Africa where condoms are much more readily accessible. In America to find a condom one had to drive or take a bus to "Walgreens, CVS and other well-established shops making it difficult and impossible to have a condom quickly enough when you need it." Consequently, participants have accepted the normality of having sex without a condom.

Perceived Susceptibility

According to Rosenstock (1974), perceived susceptibility refers to individual assessment of high risk of acquiring the disease, meaning that individual with awareness of high risk of developing the disease will get involved in risk reduction so that they should not get the disease while others who think that have low risk to acquiring the disease may not be engaged in disease prevention. In this study, the perception of

susceptibility was echoed by all participants and indicated the fear, suffering and the danger of contracting the disease - yet the problem is that they are not aware of how susceptible they are despite sharing the visualization of the pain and suffering some of their family members had to go through before death from HIV. With regards to knowing the signs and symptoms of HIV, a research question was asked how a participant can begin to recognize that their friends had HIV/AIDS. Initial thematic codes deduced from the question included fever, rash, and weight loss/fever. 13 out of the 14 participants indicated weight loss/fever and only one emphatically mentioned rash. Based on other studies that depicted immigrants knowing the danger and susceptibility to HIV, subjects in this study were also aware of the effect of contracting the disease but did not think of it as a perceived threat.

Perceived Severity

In a meta-analysis of the effectiveness of HBM variables, Carpenter (2010) indicated that perceived severity signifies individual assessment of severe health implication and the potential for higher consequences. In other words, individuals who see a specific health problem as injurious and serious are likely to get involved in the health prevention program to prevent disease from occurring. Glanz, Rimer, and Viswanath (2008) indicated that the more worried the individuals are concerning consequences or susceptibility to infection or death, the more willing they are to cooperate with safe practices or activities. In this study when asked where would they be most likely to use a condom (a) Africa, (b) both Africa/United States (c) the United States. Utilizing thematic codes 11 out of 14 participants noted that if they were to have

any chance, they would use the condom in Africa, four participants made an assumption to not have protected sex if they know and very sure that the partner did not have signs of HIV. 11 of the 14 again noted that they and their friends do not need a condom when having sex in the United States. Only four thought they would definitely use a condom when presented with the chance to have sex both in Africa or the United States. Considering the responses, the lack of perceived severity of the HIV in the United States in this population, subsequently, conveys the need for aggressive health education in this population.

Limitations of the Study

The limitations of the study included: examining of HIV susceptibility among Sub-Saharan African U.S. residents who are not infected renders the study outcome to be an assumption of what is happening in the community as opposed to engaging responses from HIV infected individuals. HIV infected Sub-Saharan African male responses may provide deeper understanding and insight into how HIV is contracted in the United States. In addition, the sample size was very small thereby limiting generalization of study outcomes. Study outcomes may not be generalized for entire African continent because of cultural, religious differences in certain parts of Africa. Nevertheless, since the study participants came from Sub-Saharan Africa the study findings are a partial reflection and offer a deeper perception among males from these regions. The retrospective research participant's self-report of their perception of risk behaviors of how this population exposes itself to increasing HIV infection rates are assumptions from their life experiences with no ethical substantiation.

Recommendations

This study explored various perception of risk factors that expose Sub-Saharan African-born men U.S. residents to HIV having come to the United States without a disease. The 14 research participants were recruited from three states covering the Delaware Valley of which encompasses Pennsylvania, New Jersey, and Delaware. A qualitative semi-structured interview was conducted to ascertain a retrospective self-report on the research topic based on their life experiences in the United States and from their country of origin in Sub-Saharan Africa. Future investigation on this topic should explore the perception of females from Sub-Sahara of what behavior risk factors may expose fellow females to HIV having come to the United States without a disease, possibly selecting candidates from various states, cities and from various Sub-Saharan African countries. Based on the significance of the sample, the study outcome could be a true reflection on what is happening in the female population of Sub-Saharan African to envisage prevention strategies. Other studies could explore this same topic on a large scale to depict what is actually happening. In addition, other studies could explore condom usage (safe sex practices) by asking Sub-Saharan women how often their male partner from Sub-Sahara used a condom during the sexual interaction.

Implications for Social Change

This research study supports optimistic and constructive social change with application by decreasing the infection rates of HIV among Sub-Saharan African-born male U.S. residents. According to the CDC (2016), this population still remains with the highest HIV infection rates in the United States. The CDC noted that infection rates in

this population are higher than black American men, white male population and even higher than the Hispanic male population. The goal of this study was to highlight and expose sexual risk-taking behavior that contributes to high HIV infection rates in this African-born U.S. population. Currently, the findings from this study indicate that most of the African-born population are unaware of how widespread of HIV is in the United States. Since there are no advertisements against the HIV disease on the radios, in newspapers, or on television, as compared to African countries where every institution has an obligation to inform its members about the disease, immigrants may have the false perception that there is no HIV in the US. Data indicates having multiple sex partners in this population is a risk behavior associated with contracting HIV. Polygamy is part of Sub-Saharan African culture, therefore, when African-born males begin to socialize in the United States, having multiple sexual partners has no uncomfortable shamefulness however this behavior results in infecting a larger population (Adedeji, 2015).

In this population, due to an increased rate of HIV, health education is essential to prevent the spread of the disease. Utilizing the study outcomes of this research and other related research on African-born immigrant, public health educators should be able to initiate preventive strategies. Preventive programs should include the impact and effects of unprotected sex, implication of having multiple sex partners, and emphasizing that if one partner contracts the disease it “can spread like fire to other partners” hence impacting the African community. Due to lack of knowledge in the Sub-Saharan African-born community of the enormity of the HIV infection rate in the United States, public health educators could use data from the CDC to educate this population of how

widespread HIV is among the U.S. citizens. Educating Sub-Saharan African-born on these respective topics would create a transformation in this population and unique preventive perspective of HIV social change in the infection rates of HIV in the population.

Conclusions

African-born U.S. immigrants have been noted to have higher rates of HIV than any other racial group. In view of this perception, this study envisaged to investigate behavior pathways that contribute to African-born U.S. immigrants who came to the United States without HIV disease but end up exposing themselves to HIV. Research questions and thematic categorical codes revealed that initially when African-born immigrants arrive in the United States they experience suffering such as lack of adequate food, financial support, inadequate living condition, lack of social support, and unemployment. After many months of struggling, they settle down - most of them pursue their destiny of the American dream. Along with furthering their dream, some feeling the freedom of being in America and leaving the constraints of the cultural taboos about women, become entangled in sexual affairs hindering their social progress by contracting the HIV disease while living in the United States. This study revealed that most African-born immigrant frown upon homosexuality as not acceptable in African culture, therefore adhering to heterosexuality norms.

Research participants in this study indicated that contraction of HIV in these African-born immigrants may occur in various ways. Having left Africa and now residing in a new world without cultural boundaries for moral constraints, the lack of familiar

rules that had bound them for self-discipline and decision-making accountability leads to feelings of non-obligated freedom. Most of the African U.S. immigrants come in the United States single and at an age when they need to explore and seek a new life plus gain identity for survival. As African immigrants endeavor to find companionship and socialize by looking sex partners while living in the United States by going to strip clubs, African bars, American bars, African parties, American parties, funerals, weddings, African associations, and brothels. By establishing close relationships with American females, these risk-taking activities expose African immigrants to sexually transmitted diseases - especially HIV. The latitude of polygamy is part of African culture, therefore, having multiple sexual partners in various cities or states could be consciously tolerated, accepted and compromised without self-recrimination. Study participants revealed the limited use of condoms among sub-Saharan Africans who reside in the United States. The assumption that HIV is very limited in the United States is widespread among the respondents. The study outcomes also indicate they don't use condoms due to limited access, as they noted every nearby grocery store and street vendor sells condoms in Africa.

After analyzing the perceptions of Sub-Saharan Africans U.S. residents of risk behavior and the pathways which may be exposing them to increasing infection to HIV, the conclusion is that most HIV infections are contracted right here in the United States. Participants noted that most immigrants are scared to have sex while on holiday in Africa because they are aware that high chance of them being infected. All 14 participants noted that prior to coming to the United States they had to go through U.S. recommended

laboratory testing and based on the result they were declared free of HIV. Therefore, if any of them have been infected with HIV while living in the United States as resident immigrants, the HIV infected residents probably have contracted the disease since landing on U.S. soil.

This study was significant in discovering the risk behavior and ways in which first-generation Sub-Saharan African-born male U.S. residents get exposed to contracting disease while residing in the United States. Though the explored finding of this study are aligned with previous studies of how African immigrants in the United States contract HIV and related risk behavior, this study was unique in that it explored sexual risk taking behavior of first-generation Sub-Saharan African males from various parts of Africa and analyzed their perception of pathways of how HIV can be contracted in this community. This study added a new dimension of knowledge in understanding of the sexual risk-taking behavior among African-born resident in the United States. Since the participants related that they mostly adhere to unprotected sex in the US, they do not engage in protected sex in the United States as a perceived health benefit due to their limited understanding of how widespread HIV disease is in the United States. Plus the cultural acceptance of polygamy may promote the acceptance of having multiple partners in various cities and states thereby increasing their susceptibility making society more subjective to advancing the disease into the community. African-born immigrants' socialization in strip clubs, American bars, African bars, African association groups, use of sex line telephone number, and visiting brothels these become trappings for social

interaction but also pathways that expose African-born residents to risk behavior in which HIV can be contracted and transmitted.

To enhance the depth of understanding of how Sub-Saharan African-born expose themselves to HIV, future studies are proposed to explore the perceptions and understanding of the female Sub-Saharan Africans and their sexual risk taking behavior. Other future studies should deal with cohort prospective studies in which arriving Sub-Saharan immigrants with laboratory test proving that they had no HIV on arrival could be followed up year-to-year and evaluated for pathways of risk behavior. The gathered data could be utilized in HIV prevention strategies in this population before coming to the United States as pre-immigration education at U.S. embassies in Sub-Saharan African countries.

As a student graduate researcher, this dissertation has provided an in-depth learning experience of how to conduct research interview, perform data analysis, learn tools such as NVivo, employ theoretic models such as HBM to help explain behavioral influencing factors, and execution of data finding. Having learned a lot from research participants and their perception of HIV in their population on how to conduct semi-structured interviews, how to organize interviews and prepare for meetings, scholarly writing and application qualitative principles, this researcher is forever grateful. These noted respective practical scholarly skills learned will enhance prospective future research endeavors.

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Appendix A: Permission to Recruit Participants

From: Henry Sinyangwe

To:

Subject: Research study recruitment.

My name is Henry Sinyangwe: I am currently a doctoral student at Walden University pursuing research in public health. My research involves the examination of factors that influence First generation male Sub-Saharan African U.S. residents who resides in Delaware Valley (Pennsylvania, New Jersey and state of Delaware) and New York to contract HIV/AIDS while living in the United States. I am writing to request the use of your facility in which I could place flyers to recruit study participants for my research.

Kindly let me now if there is any other information that you might need to facilitate the study.

I would like to thank you in anticipation of your assistance.

Sincerely,

Henry Sinyangwe

Appendix B: Participants Response

1. Tell me what life was like during your first few Months in the United States.

1EP "Very difficult financially, I some days spent without eating proper food, felt very cold due to lack of proper winter clothing. I was completely dependent on fellow countrymen. Transportation was another nightmare because of dependency on host family. I got tired of being lost by using the buses that where going different direction because of not knowing to where I was going and this resulted of me being late for interviews. The first weakness of the host family was that they did not give hard cash money that I could have used for transport making it difficult to move from point A to B without depending on them."

2SP "When I had just arrived from Africa at first, I was excited and then I realized I had nothing to do. Slept a lot since I had nothing to do. Financially, I was dependent on family members to provide food and toiletries. Transportation caused a lot of havoc because I depended on host family to take us to interviews. After I got the first minimum wage job, I still could not solve my financial problems. But the host family still encouraged me to move out. Survival was very difficult in my initial part of life in America. I ended up working overtime on daily basis just to make it through the month."

3TP	"Very difficult time of my life, the joy of being in America dissipated into sadness. As I found myself without money and dependent on my friend who vetted for my coming to USA. I slept a lot and had nothing to do for six months waiting for immigration papers. Dependence for transportation on host families was very critical. The weakness of host family was that they did not try to find out my personal needs as a result I missed a lot of job interviews due to transportation constraints."
4LP	"I was a refugee when I came USA and as a result, we had nothing except the clothes we were wearing and few belongs. I was completely dependent on my host family in assisting me to navigate around, sort out immigration status, food and toiletries. It took 3 months before I was cleared for social security. This was a very difficult time of my life. Even after I got my social security card, I missed a lot of interviews due to transportation problems. I had to wait for the host family to take me to the interview site.
5KD	"My initial life in the USA was very difficult because I was completely dependent on host family. I arrived in winter, very cold with no car for mobility this made me stay home all the time. I slept a lot, I had no one to socialize with except the host family. The host family worked all the time making it difficult to

go anywhere due to transport; it was three to six months before I could get the social security and by the time I got a job it was almost one year. I was bored and tired of watching movies. Financially, I was bankrupt, lost my independence and became completely dependent on my host family. Transportation was the major problem I experienced. I had no way out ---to go for interviews without depending on host family.

6EN "As I prepared to come to USA, I was very excited in anticipation of gazing at the beautiful city as I had been told being in USA is like being in heaven. My host family picked me up at the airport. After settling down and 3 months without social security card, my host family started panicking because I was completely dependent on their finances. Finally, after my card arrived I was told to go and work as nurse's aide so that I could settle quickly on my own. When I refused that I did not want to work in the nursing homes, I was told to leave their home. My love for being in the USA turned into a nightmare. I experienced a very difficult life here before being established. I did not know the city or where companies where located or where I was applying. Transport was a problem and I had to wait for host family to take me to these interviews."

7SP	"After my initial arrival in the USA life was difficult due to the fact that I was completely dependent on my host family. To survive at the host family house, I was told I should work all the time so that I could rent my own apartment. After I got my social security card, I started to work at the parking garage and ended up working 16-hour shifts. Working myself to death with no social life. I became disillusioned with American dream. Another thing I depended on my host family for was transportation."
8KD	"My initial experience of living in USA was very difficult especially being dependent on my host family for everything to an extent that I was so embarrassed expressing my needs. The host family just gave me a room and talked to me maybe once a day. I finally found a friend from Sudan who helped me navigate through the system and found a job at a mechanic shop fixing cars and car tires working for $5 dollars per hour. Transportation to interviews became very critical because I did not know routes where companies were located. So, I depended on host families to take me there. Waiting and requesting host family to me for interviews was very embarrassing and ended missing some interviews."

9ND	"I had big dream when coming to USA. My plan was to go to school and then later own my own shop or company but initially the whole concept of depending on host family for all my essentials just through me off, I was completely dependent. My initial beginning was very difficult after arriving from Africa. I discovered that no one gives money for free in America. My friend helped me get financial aid and started going to college. I soon discovered that by the time I am done with college I would have accumulated thousands of dollars in debt. I decided to join the Army instead and then let the Army pay for my education through the GI-bill. Transportation was a problem when I came and ended up taking wrong buses for interviews as a result missed a lot of interviews."
10SP	"Initially life was very difficult when I just arrived from Africa because I depended on the host family for everything. I was like a child. I left my wife back in Africa with a promise that in USA I will make big money and then send for her to join me in the USA. I had to stay with host family for 6 months before I could get my social security card to work. The host family, who happened to be my friends, were very generous in that they allowed to stay at his house for more than two years. To avoid bothering the host family for money, I learned to fast and not

bother them for toiletries. Sometimes I would eat once in three days. I thought I would compensate the burden of being a parasite by helping around the house, but still felt inadequate. Unfortunately, I have to say to wait for a social security card made the situation even worse. I spent more than 3 months in the house doing nothing but just helping with house chores. Transportation was a nightmare because I did not have money for taxi-cab for buses did not know the routes. After I got the Social Security card the nearby laundromat employed me to do work on clothes. I was getting minimum wage not enough pay rent. My host family encouraged me to move out of the house but when I started living alone, I had no enough money to pay rent, electricity and food. I ended up on food stamps to survive."

11KD "I migrated from Africa to USA 13 years ago and upon arrival I had a very difficult life. I arrived with $10 in my pocket. I became completely dependent on my host family. It took 3 months to get social security card. After I got social security card, I was told to look for a job and start planning to find my own accommodation. Soon I found a job at Amazon warehouse where I worked 12 hours a shift. I felt particularly awkward about imposing my suffering on the host family, because the host family was just my acquaintance my relationship with him

was not very extensive. The host family we had just met each other while visiting Kenya. When I arrived, he had a low paying job and he was not expecting me when I called him to act as host family for my USA citizenship. Lack of transportation was one of the reasons I missed lots of interviews."

12NP "I came to the USA because my mother had already been here. Initially l was very bored because I had no social security card and as a result, I slept a lot since I had nothing to do, I was completely dependent and did whatever she wanted. After I got social security I started going to college and my mom paid for my education. I would say I had an easy life initially while settling in the USA. Lack of transportation was one of the factors that delayed my independence because I had to wait for the host family take me for interviews because I did not know route the buses used."

13CD "I arrived in the USA 15 years ago. I was lucky my mother had come to school in the USA and then after finishing school she found a job to work as professor. Then she invited us kids to come and join her. When I arrived, I had $1.00 in my pocket as a result I was very dependent on my mother. After I got my social security card my mother found me a part-time job and let me go

to school part-time. I would say my initial experience of settling down in the USA was not difficult for me."

14ZD "My initial experience of settling in the USA very difficult. A friend of my mine I had met in Africa acted as host family, but the problem was that he almost lived in poverty due to financial constraints. When I came to his house, I made the situation worse since I dependent on him for his survival. Therefore, joining him in his house made me become an extra burden to feed and to take care of. As a result, I really struggled. Sometimes eating once, a day or once in two days. My friend finally one day said you better find a job to take care of yourself. This friend of my mine we came across each other in Africa so I asked him to act as host family if I filed for U.S.A. citizenship but the problem was that he almost lived in poverty due to financial constraints. Therefore, joining him in his house made me become an extra burden to feed and to take care of. As a result, I really struggled. Sometimes eating a decent meal once a day or once in two days. My first job I got was minimum wage job as a result financially I was still strapped for almost two years before I could find a decent accommodation. After my social security card arrived, transportation was a major problem. Bus stations were 3 miles away therefore, going for interviews

was a major problem. To go for interviews, I had to wait till the host family were off work so that I could be taken to attend to interviews."

2. Tell me about your daily routine after arriving in the United States and how did it differ from life in Africa?

1EP "In Africa I would wake up, go to work and come back after working 8 hours. In the evening I would visit with my friends, cousins, and get home around 10:00pm have a quick bath and went to bed. In America I work long hours to survive, often scared to be outside, no friends, feeling isolated. Once every 3 years I go to Africa to relax to be free from the pressure of living in America."

2SP "Daily routine in America are geared to survival. Since arriving in the USA, it is all work, work, work to survive. It is difficult to visit friends and family without appointment. In Africa not everything is money. I went to work with no pressure to survive and when I came home since I was not married helped around the house, visited family members without appointment."

3TP "In the USA, this part of the region is cold, winter season is longer than warmer months. I don't like cold weather as a result found myself staying in apartment with very few male friends. In Africa weather is warm all year round; when I am there, I can go

	to any place any time I want. Currently, I go Africa every 2 years. I like living in USA because there is less corruption and strict laws that makes everyone accountable than in Africa."
4LP	"In Africa I work as laboratory assistant. I worked at speed I wanted and the job was done efficiently. Initially the routine when I came to the USA was to start going to school. So, I went to school part-time and worked full time but also, I have ended up working extra hours to survive. Living and surviving in Africa is easier than living in America. In America everything is money. I go to Africa every 4 to 5 years if I have money."
5KD	"My initial experience of living in USA was a culture shock. In Africa people go to bed early and by midnight nothing is moving especially in rural areas while in the cities you will see very few cars. However, in the USA I discovered that there is no night. People can live, socialize and work at night. As a result, after receiving a green card I found my job as a night shift worker at Amazon. The host family have been gracious to keep me until I am financially stable to be on my own. My daily routine involves sleeping during the day and working at night. On Sundays sometimes, I go to church. Most of time I slept a lot, I had no one to socialize with except the host family … I was bored and tired of watching movies."

6EN	"After arriving in the USA my initial routine involved watching TV a lot and sleeping a lot since I did not have anything to do. After finding a job, then my routine included working, socializing for a beer, and enjoying entertainment at African association club, or sleeping and still watching TV - especially soccer. My love for being in the USA turned into a nightmare. I experienced a very difficult life here before being established."
7SP	"After receiving the social security card, I managed to find a job that finally gave me a financial stability. I started working 12 hours shift just to have enough money for rent and food. The difference between living in America and my native country is that in my native country I did not have to work hard for survival. My daily routine has been evolving. If not working, I visit fellow countrymen from Sudan and on weekends I try to go for prayers at the mosque."
8KD	"I arrived in the United States in January and the winter season of that year was very cold. I wished I had not come to this country. I spent the first 4 months hibernating in the house of host family. I was cold and miserable. Due to lack of green card I could not find work consequently my routine for the first year involved a lot sleeping, visiting African parties, bars, and African gatherings. Visiting these groups expanded my thinking

for it made me see the kind of social life African immigrants are involved in." inactivity caused me to regret my decision to move to the United States, slept a lot to pass time. I wished I had not come to this country. I spent the first four months hibernating in the house of host family. I was cold and miserable"

9ND "I was lucky when I came to the United States. My Aunt was already married and well established. So, when I joined them as my host family they had already established some ideas of how I could survive as a US citizen. After I got my social security card the host family had a meeting with me. During the meeting they insisted that I make quick survival decisions. First option was to join the Army for 5 years then after which I could use the GI bill to pay for my education. The second option was to go to school get financial aid and loans to fund my education and then pay back the loan after I found work. During this meeting I decided to join the army and get the GI bill to fund my education. After this meeting I joined the Army and started training as a Marine. After I join Army my routine involved training during the week and off during the weekend which I went to church and visited friends. While in the Army I had chance to visit other countries especially Europe and Asia. My initial beginning was very

	difficult after arriving from Africa. I discovered that no one gives money for free in America."
10SP	"I arrived in the USA through the lottery program. Upon arrival I was taken to Social Security Department and to get a social security card. I registered but it took another 3 months for the social security card to come. During that waiting period my routine involved getting up in the morning and holding Muslim prayers, eating breakfast, and then going out to socialize with fellow African immigrants. When the city was hosting basketball or football, they would get me a ticket and we would spend most of the day out at these sporting events. If there was an African wedding or social event we would go and interact and socialize with fellow African immigrants. The difference between my routine in Africa and routines in the United States is that it cost less to socialize in African than in America. In the United States, every person must have money in order to have fun."
11KD	"I arrived in the United States with just the clothes I had on my body and therefore, life was very difficult. The host family was just an acquaintance I came across who was visiting Kenya. When I arrived, he had a low paying job and was not expecting me. After my arrival, I went and registered for green card. It took 5 months before I could receive my green card.

Consequently, I could not work. My routine was to get up in the morning just go for a walk, eat, and go to bed. Sometimes since we lived near a football field, I would get my soccer ball and go and play by myself. In Africa, since I worked as an IT specialist, my routine involved going to work during the week and then over weekend I visit family members, go to church, socialize mostly with my cousins to watch soccer competitions and most of the times ourselves we would form a soccer team and play with others."

12NP "My mother was a teacher came for further education and the she decided to become an American citizen. Therefore, when I arrived my mother was already established. While in the USA, she had become a college assistant professor and had an established African grocery store. After obtaining my green card, my mother enrolled me into college for business degree. Therefore, my routine included: going to college early in the morning and helping as a shop keeper in the afternoon. On weekends I went to church and sometimes played basketball or soccer with my cousins. When I lived in Africa I went to a technical college and my routine involved going to work in my uncle's shop part-time. When I had free time, I spent time with my girlfriend and sometimes she spent time at my apartment.

Life in Africa is easier to live than in America. Demand for money to survive makes it very difficult."

13CD "When I arrived on the lottery visa from my country to USA, I had already planned to establish a laundromat. Therefore, after I got a social security card, I immediately enrolled in a business school. My early routines included going to school, going to work in the laundromat as an apprentice part-time job and learning how to play basketball and football with my cousin since these types of sports games were new to me. In Africa my routines were more fun because there was no limitation on time. In Africa, I had couple girl friends and I had enjoyed spending time with them. In Africa we had a soccer team and played a lot against other teams. The difference between Africa and America I have seen is that in America must do everything to survive because of financial demands on survival while in Africa you very little money to survive on."

14ZD "I arrived to America on a lottery visa. The host family was just a friend of mine I happen to meet as college class mate in Russia. So, after finishing an engineering degree in Russia I went back home in Africa. Then we communicated and he agreed to act as a host family in USA as I pursued the lottery immigration to citizenship. After I arrived, since he was single,

we had to share a one-bedroom apartment. I had no money whatsoever, completely depended on him. After getting my green card he asked me that I should find a job and live on my own in 2 months' time because he was about to get married. On arrival I didn't even know where to look for a job. My morning routine involved eating breakfast and going to buy newspaper to look for job advertisements. Most of my early life in America involved working overtime like a dying person. In Africa my routine was casual, no pressure, just living life and relaxed. In Africa I had a girlfriend I spent most of the time with. I worked part-time and performed house chores at my parents' residence. I had no worries in Africa; but in America to survive was like hell broke loose. I became disillusioned with American dream."

3. What were your financial survival experiences? (Did you need to look for a job immediately upon arrival or did you get Financial support to sustain you?)

1EP "It took 3 months to receive the Social Security card. After getting it, I immediately started looking for a job because I was so bored being at home doing nothing. Unfortunately, it took another 2 months to find a job. At this point I didn't care what kind of job it was, I just wanted to work. Very difficult financially, and some days spent without eating proper food."

2SP	"After arriving in the USA, I thought I will immediately find work only to be told that I needed social security card number to be paid to receive money from any company. Due to lack of social security number I had to wait more than three months. This was the most boring time of my life. Routine involved, watching TV, going for walks, eating, and going to bed at midnight. Due to lack of work, I financially became dependent on host family. Since I did not know anybody in the vicinity for financial support, especially transport money which I needed badly for attend job interviews."
3TP	"I was completely dependent on host family for both survival and well-being. I arrived with $5 in my pocket from Africa. My host family picked me up from the airport. After that I was stuck in the house waiting for my Social Security card for more than 3 months. Even after the social security card came, I still had problem attending interviews due to financial constraints. My host family worked all the time and they ended up giving me money for a taxi but was not sufficient to go for 5 interviews. I ended up cancelling job interviews due finance problems this made me even more frustrated. Another thing that frustrated me was my English was not that good. So, during interviews I

	would repeat sentences and words just to make the interviewer listen to what I was saying with regards to my job experience."
4LP	"Since I had no social security card, I had to wait 3 months before I could even start looking for a job. Financially, I was completely depended on the host family. Even after I got my social security card, I missed a lot of interviews due to transportation problems. I had to wait for the host family to take me to the interview site. Taking a taxi was a risk since I did not know the cities or locations. I was afraid I might me hijacked. After I found a job, I still had transport problems. The buses did not go by my work place. I ended up walking another mile to reach the destination. I had to work another 6 months before I could afford a loan for a used car. Food wise, I had to navigate the system and ended up on food stamps from the government."
5KD	"It was very difficult finding a job after just arriving from Africa. My accent was strong and level of English was very poor. After getting my social security card, I sent a lot of applications to nearby factories. None could give me a job. Finally, I got a job in a distributing company even then it was a bad minimum wage. Transport was a problem. I had to work another 9 months before acquiring a used car.

6EN	"Due to lack of social security card and green card no one wanted to employ me. I had to wait 3 to 4 months. After getting the green card and social security card I still did not know what to do. I did not know the city or where companies I was applying to were located. Transport was a problem and I had to wait for host family to take me to these interviews. Initially I have to confess my English was a problem and where I came from in Africa we never spoke English. In fact, I was scared to go for interviews."
7SP	"To get a social security card was a greatest milestone but it took 3 to 4 months before I could get the card. My host family continued to take care of me and paid for toiletries. When the green card came and it was time to go for interviews, I had only 2 cents in my pocket. I was embarrassed to ask for money for a taxi or the bus. When I told host family about the interview, they were excited and only gave me $20 for taxi but this was not enough for scheduled 3 interviews. After I got the first minimum wage job, I still could not solve my financial problems. But the host family still encouraged me to move out. Survival was very difficult in my initial part of life in America."
8KD	"I Stayed about 3 to 4 months without a job as I waited for a social security card. Financially I was strapped I could not wait

to find a job. I looked forward to that day when I could finally free myself from begging money from host family for everything. The church group members and fellow Africans who knew about my suffering helped but it was not enough. After the social security card came my first job was minimum wage. I ended up working overtime on daily basis just to make it through the month."

9ND "In America employers are scared to give you a job without a social security or green card. While waiting for social security card due financial constraints and poverty I begged for a job at two different places but employers refused. As a result, I had to wait more than 3 months before receiving the social security card. After I received the card, due to poverty and suffering, I immediately looked for a job. Though the initial job at the restaurant paid minimum wage, at least I was able to survive."

10SP "I had to wait more than 3 months before I could get social security card. After I got the card the nearby laundromat employed me to do work on clothes. I was getting minimum wage not enough pay rent. At some point, my host family encouraged me to move out of the house but when I started living alone, I had no enough money to pay rent, electricity, and food. I ended up on food stamps to survive. I had some friends

from Africa fellow immigrants I noticed that they had the same problems I was experiencing. At some point I started feeling that I was an embarrassment to host family as a result I started fasting to avoid making myself - more of a burden to the people who were keeping me. In addition, to avoid bothering the host family for money fasting became a solution."

11KD "I was lucky coming to the United States because some of my family members where already here. Initially I lived with my cousin but my parents had enough money from their businesses that they were able to support me. While waiting for the social security card, I helped at home with chores and went out to visit friends from Africa when my cousin was off from work. My parents would send me about $50 every month to meet my needs. After receiving the social security card, I joined the Army as a reserve."

12NP "My mother was already here in America when I arrived. As a result, though I was old enough, I did not need to fend for myself. My mother was already established when I came. Consequently, I was given pocket money in addition to being taken care. My initial routines while waiting for a social security card involved helping at grocery store, going to visit my uncle and cousin and on Sundays and we went to church. Financially, I

	was stable because of the weekly stipend I received from my mother."
13CD	"Mother came to the USA as a teacher and decided to immigrate. After a while she filed for immigration to help me come to the United States. When I came, I lived with her so I did not have any hardship. She just encouraged me to wait for social security card before I did anything. After the social security card, she registered me at college to go for a second degree."
14ZD	"When I came to the USA, I had no money. As a result, my life depended on the host family. Toiletries, transportation, and food - these were crucial to my survival. Unfortunately, to wait for a social security card made the situation even worse. I spent more than 3 months in the house doing nothing but just helping with house chores. After my social security card arrived, transportation was a major problem. Buses were 3 miles away therefore, going for interviews was a major problem. To go for interviews, I had to wait till the host family were off work so that I could be taken to attend to interview. My first job I got was minimum wage job as a result financially I was strapped for almost 2 years before I could find a descent accommodation."

4. Tell me about your social support groups and how did they provide for your needs.

1EP	"My host family were the only support system who happen to be distant cousins. I tried to get help from the church and other immigrant friends and organization but nothing forth coming."
2SP	"The host family wife never worked and that made it very difficult as we all depended on the man of the house to provide all my needs for resettlement. I tried my best to call my sister and brother in-law who lived in a different state but got no help."
3TP	"The host family provided and met most of my immediate needs. Food stamps also became handy. The African organization provided me with selected used clothes."
4LP	"Since my immigration status was partial refugee, when I arrived the USA government was obligated to put me on USA welfare status. Being an immigrant allowed me to be qualified for monthly stipend, food stamps and transportation voucher."
5KD	"The host family provided me everything I needed. Both the husband and wife worked. Transportation was the major problem I experienced. I had no way to out to go for interviews but once in a while people from church helped."
6EN	"The host family provided all my needs. Once in a while fellow immigrant wound invite me into their homes for a quick dinner."

7SP	“The host family supported me for everything, my church helped, and some friends would help me with transportation to go for interviews.”
8KD	“My host family helped me with everything. Fellow immigrants donated food and some clothes since I had no clothes.”
9ND	“The host family provided most of my needs. Also, at church there was a fund raiser to help the needy in the church and I received some financial donations that helped with job hunting and transportation for interviews.”
10SP	“The host family provided most of the needs. I had a cousin who was already here in America who was also was helping. I remember one time I was very sick with dental infection. She came and took me to the hospital and she paid for tooth extraction.”
11KD	“The host family provided everything. A distant uncle who lives in another state sent me some money to help out with personal needs.”
12NP	“The host family gave the needed support which I initially needed badly. Some church members would also invite me to their homes just for a fun outing but did not give me financial support I so badly needed.”

13CD "My mother was a teacher and she was the host family who supported me and later on put me in school."

14ZD "The host family was a Liberian friend and though he had not enough money we managed to pull to through until I got my first job."

5. What were the strengths and weaknesses of your support group?

1EP "The strength of the host family was that despite of few resources they had, they opted to host me as their guest. Another strength was that they provided me with accommodation, food and toiletries. On some good days when off from work I was taken in their car for interviews. The first weakness of the host family was that they did not given hard cash money that could have used for transport. Initially I did not like America food." The second weakness of host family was lack of guidance because did not take time to show me the community we lived in or bus station. My initial winter also proved to be very cold because did not have adequate clothes, shoes, and beddings and as result pains of that winter I still remember it like yesterday.

2SP "The weakness of host family was that they never included in me into family time like camping or when they decided to go out for some functions and this made me lonely and isolated. The

strengths of the host family were that they provided me a room to sleep-in for free and provided food and toiletries. Sometimes there was minimal socialization for example host family friends would come and showed me how play basket- ball and football and that was fun. Moreover, I also had problem with American food." Another weakness, was lack of guidance or did not bother to show me the city or transportation routes. Again, due to lack of guidance made lots of mistakes during winter season. I did not have adequate warm clothing or beddings. I very cold during my initial winter.

3TP "The strength of the host family was that they provided me with food, accommodation, and sanitation amenities. The weakness of host family was that they did not try to find out my personal needs as a result I missed a lot of job interviews due to transportation constraints. Another thing that frustrated me was my English was not that good. So, during interviews I would repeat sentences and words just to make the interviewer listen to what I was saying. Another weakness of host family was that they never included in me into family time like camping or when they decided to go out for some functions and this made me lonely and isolated. I also had actualizing to American food. Another weakness was lack of guidance. Even after I moved out

	they did not tell me where I could get specific supplies. Again my initial winter was very brutal mostly due to lack of guidance on clothes, shoes and beddings and mostly because I had never seen winter before."
4LP	"The weakness of host family was that they did not support me financially - reason being that I had a refugee status and the government sent me a stipend for living expenses. However, this money sometimes came late and consequently I had to fend for my self during that period. I just think they should have asked if I had everything I needed. The strengths of the host house were that they provided housing for free and food in the initial stage of settlement. They also provided transport for interviews if not working, but I had problem with American food due too much cheese. Every dish I tried had cheese on it and made me constipated for days. Lack of giving me guidance was another weakness my host family experience. I don't remember him telling me which places to avoid for security reason or where to buy what and what. I had to figure out by myself. During my initial winter in the US, I was very cold because winter clothes and beddings were both of poor quality. Most of it was lack of guidance on how to survive the winter."

5KD	"The host family provided me with accommodation, food, and toiletries. The weakness was that host family never included me in family time apart from going to church. I was very lonely and felt isolated due to fact that I had a bedroom in the basement. Could not interact because initial my English accent was thick and people had problems understanding me and also American food was very difficult to get used to though I ate American hamburgers every day. Another weakness was lack of guidance, did not show me shopping center, restaurants or bus stations."
6EN	"The host family strengths were that they provided me with everything I needed like accommodation, food and transportation when needed. The greatest weakness was that when I came, I only spoke my local language and the host family spoke only English and at times it made me very frustrated because we could not hold the conversation. Definitely language barrier was a problem. Another problem was my English-accent. My English accent different as a result I was hesitant to participate in job interviews because of fears that I would be unable to express my English adequately. Initially I have to confess my English was a major problem and in-fact where I came from in Africa, we never spoke English. Another weakness was lack of guidance. Did not show even the

community we lived in or how to call the taxi. Winter clothes and beddings were inadequate during my initial winter as a result felt very cold that year."

7SP "The weakness was that I only ate American food as I never had enough money to buy African food. I was not used to American food dishes so eating pizza, sandwiches, and spaghetti all the time became very boring. I had no money to buy African ingredients to make African foods. The strengths of host family were that I was given free accommodation, free food and at times helped with transport to go job interview. I found African food very expensive, however, though I was not used to American food dishes soon I familiarized myself to eating pizza, sandwiches and spaghetti this change occurred because I had no money to buy African ingredients to make African foods. Another weakness of host family was that was that they never took time to show me the city vicinity or just to socialize in the nearby communities … I used to get lost all time. I did not know where I lived or where I was going to work and by the time, I got permission to work I did not know the surrounding neighborhood or the city I lived in. Another weakness of my host family was lack of giving me guidance. He did not show me even how to make a phone call or bus station and routes as result

got on wrong buses. Also, winter proved very cold for me due to lack of guidance about the season. I remember one day I just wore a T-shirt; I thought the weather will get better but never did as a result became very cold that day."

8KD "The strength of host family was that they very happy to have me home. I made them laugh a lot with African stories. In addition to providing accommodation and food they also provided me with weekly $20 for transportation if I needed to go for interview. The host family weakness was that they were not aggressive enough to help me find a job. As a result, finding a job was very difficult since I did not know how the system worked. Another weakness of host family included lack of socialization with me. Never invited me when they went out for some functions this made me stay home most of the time since I did not know the community. In addition, I have to confess, initially when I came, I had difficulty getting used to American food. Lack of guidance was another weakness I discovered in my host family. He did not show me even how to call police in emergency situation or bus routes or where to buy what and what. My clothes for winter were inadequate due to financial constraints but also due to lack of guidance about winter season for example knowing what not to do during winter."

9ND "The strength of host family was that they provided me with food, accommodation, and any essentials that I needed for initial survival living in the USA. The weakness was that there was no social life. I stayed at home most of the time. As I watched TV crime scenes, even that made me scared to go out in the neighbor hoods for walks. Another weakness was lack of guidance. He did not tell me where restaurant where located or hospitals. I also had poor clothing for winter due to lack of guidance.

10SP "The weakness of host family was that they never took time to show me the city vicinity or just to socialize in the nearby communities. As a result, after I got the driver's license trying to drive in the neighborhood without GPS at that time proved very difficult. I used to get lost all time. I did not know where I was or where I was going. Strength of the host family was that they provided me with free accommodation, water, electricity, and toiletries for 2 years without compensation. However, I always looked forward to Sunday to go to a place of worship and this helped me to interact with other Americans. Even though I was not very close to host family I had to ask for their opinion before making a big purchase and this worked to my advantage. For example: the host family told me that Walmart Shopping Centre had the cheapest furniture and other

kitchen related household products and as a result I avoided other shops and purchased affordable products when I started working for my small apartment. Lack of guidance was another weakness I discovered in my host family. He did not even tell me how to use the clothing washer, dry or dish washer. In-fact I almost cut my fingers with garbage disposal. I didn't know even where the nearest hospital was located or how to call 911 for emergencies. My initial winter proved to be very cold for me again due to lack of guidance of right clothing for the season."

11KD "The strengths of host family were that I stayed with them for 3 years while they provided me with accommodation, food and transportation driving me to job interview. The weaknesses included lack of socialization this made stay home most of the time since I did not know the community. I liked when we had some minimal socialization --on and off I went jogging with friends of host family members and watched neighborhood soccer games but it became boring as I watched the same thing over and over, moreover, I still problem with American food. Lack of guidance was another weakness. He did not even show me how to call 911 or nearby shops. My first Winter in the USA proved to be very cold because I did not have right clothing for the season."

12NP	"The strengths included free accommodation, food, and toiletries for 3 years. So, I am thankful for the sacrifice they made. The weaknesses included no pocket money until I started working on my own. I think they should have asked me I needed anything. There was no social life or going out. I didn't know the community very well initially and I was just scared to venture out by myself. I also had problem getting used to American food." I remember one day host family brought in TV dinners and spaghetti dishes which tasted like porridge every time I ate the food. Another weakness was lack of guidance in that he never took time to show me the neighborhood when I arrived. I could have been killed because I ended up walking in bad neighborhood looking cigarettes for a smoke. I did not have winter clothing which proved very difficult because did not have warm jacket initially until in the middle of winter."
13CD	"The strengths include that the host family provided me with free food, accommodations, and other essentials like toiletries for free for 3 years until I was able to pay rent at my own apartment. The weaknesses were mostly related to lack of guidance especially, job hunting, shopping and how to operate things-garbage disposal, dish-washer and dryer. I did not feel helped when I started looking for a job. Since the host family

knew the industries in the host cities, they should have directed me to which one was a nearby factory or told me which ones were distant. Also, when winter came, my host family did not provide me with enough warm clothes. So, my first winter in the USA was very cold. I am still thankful with any contribution they rendered to me during my first year in America especially getting used to American food, though did not like it, I still ate it in order to survive."

14ZD "The only weakness I can attribute to host family was the social life. There was no social life or going out. I didn't know the community very well initially and was just scared to venture out by myself. The strength of host family was that they provided accommodation and food for free. American food was very difficult getting used to, I had a lot of diarrhea because of lactose intolerance to cheese. Lack of guidance was a problem. He did not show me shopping centers or restaurant or how to call 911. I also did not have Winter clothing because I did not know anything about winter."

6. Tell me some places that your African friends go to socialize.

1EP "Since coming to the United States, most African close friends socialize in bars, African ceremonies such as Independence Day for each country, weddings, and African restaurants."

2SP	"My friends from African most of the time they congregate at churches, weddings, African Associations, homes for birthday parties and independent days for different countries. Including, Red light district clubs for women, social gatherings and nightclub for homosexuals."
3TP	"As African's most of the time we congregate at churches, weddings, African Associations, homes for birthday parties and independent days for different countries. Some groups even go to strip club."
4LP	"My friends, when free from work, can attend church, congregate at parties, attend weddings, socialize at bars, and attend African association group."
5KD	"Truthfully, speaking I have never been in a bar or strip club. However, I have seen ourselves attend church, weddings, birthday parties, African Association, and independent days."
6EN	"My friends encourage me to attend the mosque, African bars, African restaurants, weddings, African association group special day and birth day parties."
7SP	"I will speak for myself, we usually go to the bar, weddings, attend spiritual gathering at the mosque, African association group, birthday parties, and sometimes just gather at one of our

	friends and watch African soccer games. I have never been in a strip club."
8KD	"I have seen some of my friends visit African or American bars, African restaurant, attend church or mosques, African association and go to soccer stadiums to watch soccer games African immigrants contract HIV especially by visiting sex clubs."
9ND	"I have seen my African friends attend church, go to bars, strip clubs, weddings, African associations, and attend African birthday parties."
10SP	"Since I have been in the United States, I have seen African's gather for birthday parties, African association group, church, at African restaurants, African funerals, basketball stadiums and soccer stadiums."
11KD	"I have seen African men attend African bars, African parties, funerals, African association, weddings and churches or mosques. African-born males might contract HIV by going to sex parlors."
12NP	"When I just came from Africa never thought Africans socialize. After a while I have seen African go to strip red light clubs, churches, birthday parties, African Association, bars, and African restaurants."

13CD "I have seen African congregate at funerals, weddings, bars, strip clubs, church, mosques, African association, and soccer stadiums. I have also African born visit Red light strip clubs."

14ZD "I would say myself and my friends have attended churches, funeral gatherings, bars-dancing clubs, weddings, African associations, and birthday parties. I have also seen African born immigrant visit singles strip clubs and African single parties which are frequently held among African born communities.

7. Tell me about three social activities that have changed since coming to the USA compared to how you socialized in Africa.

1EP "In Africa I had lots of friends and family members to associate with and visit. I never cooked or cleaned the house. However, since coming to the USA I have found it difficult to have friends. I cook and clean, never drink or go to bars. I just work, work, and go home and see my wife. We go to church and visit friends and that's it."

2SP "In Africa I worked only 8 hours and no overtime. I visited my aunt, sisters, cousin, and uncles. In the USA, I don't have family apart from my wife. My relationship with my wife has grown closer since it is just us and some friends around. All I do is work, sleep, and pay bills."

3TP	"In Africa I would drink in the bars once in a while, visited family a lot. In Africa, visited friend and family without appointment. In America there are no relatives just distant cousins and friends. In America I have to make appointment to visit anybody- everyone is busy and has no time to visit. In America, I don't go to bars but just buy beer and bring it home and drink at home."
4LP	"When I lived in Africa there was war and people being killed everywhere. I was not married then just lived with family members. I did not clean or cook. Since coming to America, I have married with children. I have some friends and family members I visit here and who visit me. I never drink. As a family we go to church and socialize by going to the movies and head back home. In America I work hard to survive, more than I did in Africa."
5KD	"In Africa I and my friends after work we would go to a bar and have couple beers. I visited my uncles, aunties, and friends with no appointments. Since coming to America, I have to make appointments before visiting them at home. In America I work hard to survive – more than I did in Africa. In America I do socialize by going gambling at casinos, I go to a bar once in a

while because I am scared of being shot in a bar – more gun violence than in Africa."

6EN "In America it is difficult to have friends because everyone is working hard to survive. Even if you have friends you may only meet once a week because there is no time to fully socialize. I don't drink beer. I go to church and then go home. While in Africa I would visit my cousins, uncles, aunties, and friends with no appointments. In Africa I did not have to work hard to survive. In Africa just working 8 hours was enough to live comfortably. In America I have to work overtime to survive."

7SP "I like living in America because there is peace, rule of laws. Everyone obeys the laws and political stability. In America I work extra hard to survive but the benefit is that I have good health care and I can see the Doctor any time I want. In America there is good healthy life. In Africa when I was there, I experienced political instability, bad health care system and very difficult life."

8KD "In Africa I worked and visited uncles and aunties and friends frequently. Worked for 8 hours and went home. In Africa I had less money and I was comfortable. Never drink beer. In America life is comfortable and when you have a car you can go anywhere. In America I work hard lots of overtime in order to

survive. I have been able to go to most of East coast of USA beaches with friends, bowling and playing soccer just for fun."

9ND "In America I work lots of overtime to live comfortably and to have an easy life, car to drive and be able to pay all the bills. In USA it is difficult to make friends because everyone is working hard to survive. In Africa there is a scarcity of jobs, I experienced a very difficult life although as the family we lived together and shared a lot of things to survive. I do not go to nightclubs or drink."

10SP "In Africa I experienced political instability in my country and because of war life was miserable. In the country very few people worked because of war. Therefore, I am thankful to be in the USA where there is rule of law and peace. In the USA I work very hard to survive and pay all the bills but life is comfortable. I do drink beer at home and not in bars. I go to the mosque for prayer with my family and we feel blessed to be in America."

11KD "In Africa there are less laws compared to USA. Even if there are laws in Africa, there is nobody to enforce the laws especially in the rural areas, and because of this people are freer in Africa than in America. In Africa I experienced a lot of poverty - a situation where you don't have enough food for 3 meals. In Africa even if I worked hard sometimes you don't get much out

of your hard work. In America due to good governance and political stability people are able to gain more from their work. To socialize in America I go to church, ocean beaches, sports stadiums and visiting friends and distant cousins who live in the USA. Life is easy in America and comfortable."

12NP "In American I work extra hard to survive compared when I lived in Africa. In America I pay a lot of bills such as life insurance, medical insurance, electric, water, garbage, and sewage by the time I finish paying for all these items there is no money left. Therefore, I have to work overtime to survive. In Africa I took a bus to work and never paid medical bills. To socialize in America, I go to coastal beaches, once a while take friends to a bar for beer, and also take my family for bowling."

13CD "In Africa I survived by working at a small company and worked only 8 hours. While living in Africa I did not have to pay so many bills such as water, electric, garbage, sewage, mortgage, and car bills. In Africa life was easier but not as comfortable as in America. I visited my brother, uncles, and cousin without appointments. However, living in America is very comfortable and pricey. I have learned to work extra had to survive here and be able to pay all the bills. To socialize I take

my family to church, coastal beaches, museums, bowling, and zoo - even though all these things cost money."

14ZD "In Africa I had no job and just helped run the farm and because of that I was financially very poor. Coming to the United States has enabled me to become what I wanted to be when I grew up. In America I have managed to find a job that pays for my education and able to take care of my wife and 2 children. I am assured comfortable living in America than Africa. To socialize in America, I take my family to the zoo, museums, coastal ocean beaches, movies, and bowling. I don't drink."

8. What are the differences between the male and female relationship in America compared to Africa?

1EP "In Africa male and female relationship is not mutual. Females are submissive, loyal, and respectful to men compared to America. In America women are equal to men and relationship can be very difficult because no one is leader in the house or relationship. With regards to work in this country, all I do is work in order to survive especially overtime just kills me."

2SP "American women are indoctrinated with equal rights with men. Equal rights give women power extending that power into the house and weakening man's responsibility and authority. As a result, American men became weak and not able to assume risk

to protect family. In Africa because of women's submission to man, men take risk at all cost to protect the women and the children. With regards to work back in Africa I worked 40 hours a week but in America I work almost 60 hours a week in order to survive."

3TP "In Africa because women are submissive to them men use their power to solve family problems and take risk to die for sake of the family. In America women have equal rights and so a man thinks my wife will take care of the problem too and because of lack of leadership divorce rate is high. Equal rights in the house makes women disrespectful to men just as men might be disrespectful women because no one is leading or guiding or to look up to. Another danger in this country is work. In order to live a decent life as immigrant one has to work hard."

4LP "In America the male and female relationship is equal. In America men have been weakened and fear to take responsibility and let the woman control a man and the house. Therefore, men can easily run away from the house because they don't feel responsible and also feel the woman can equally take care of it. In Africa, because women are submissive to man, the man can't run away from the house because he feels he is the custodian of

the house. With regards to work I have work more than 50 hours a week. My friend even goes up to 80 hours."

The man does not feel responsible for the woman and nobody is a leader. Therefore, this shared sexual relationship of equal rights makes the man weak and can easily run away from it without accounting for his responsibility."

5KD "In Africa men take greater responsibility for well- being of the house as a result the woman has to be submissive. In Africa men take the blame for divorce and all the problems that household encounters and not the women. In America women have equal rights to that of men and as a result share the blame. However, equal rights make the man weaker and become dependent on the woman. Due to equal rights, women in American household control the house. Men don't feel responsible for anything. With regards to work, it takes a way the beauty of coming to America because All I do is work to survive. In African you don't need to work everyday to survive. In Africa I and my friends after work we would go to a bar and have couple beers. I visited my uncles, aunties and friends with no appointments. Since coming to America, I have to make appointments before visiting them at home. In America I work hard to survive – more than I did in

Africa. In America I do socialize by going gambling at casinos, I go to a bar once in a while."

6EN "In Africa men take responsibility to marry a woman and pay the bride price therefore a woman has to be submissive to a man. The bride price makes the man to became the custodian of the house. Therefore, the man takes all the risks of meeting needs of the house. In America marriage is a shared responsibility and both men and women take equal right and responsibility. However, this has weakened the American men and women feel more responsible for the well-being of the house and feel obligated to exert control. With regard to work, all I do is work—work Monday to Friday. In Africa just working 8 hours was enough to live comfortably. In America I have to work overtime to survive."

7SP "In Africa, like in Sudan or Moslem countries, men don't have even access to women. To marry, the man should go through the parents of the woman and pay the bride price. After the man takes the women, the man is responsible for taking care of the woman. The man has to take risks and responsibility for the needs of a woman. In America it is a shared responsibility because of equal rights. The man does not feel responsible for the woman and nobody is a leader. Therefore, this shared sexual

relationship of equal rights makes the man weak and can easily run away from it without accounting for his responsibility. The other problem in this country is work. One to survive needs work, well Africa we don't need to work for somebody to survive."

8KD "In Africa, women are submissive to men due to culture and tradition of letting the man take risk and greater responsibility for marriage relationship. In America equal rights makes both parties responsible for marriage. However, I feel this has weakened American men and do not feel responsible to take care of the woman thinking she can take care of herself. Another problem is that I have to work hard in order to survive in the country. In Africa working 36 hours to 40 hours was enough but in America I have to work 50 to 60 hours to survive. In America equal rights makes both parties responsible for marriage. However, I feel this has weakened American men and do not feel responsible to take care of the woman thinking she can take care of herself."

9ND "In America, because of equal rights, women feel empowered to exert power in the house. The shared equal rights make both men and women to cook and clean in the USA. In Africa, women are submissive to men and men exert more power on

	marriage relationship by taking greater responsibility in protecting, caring, and providing for every need of a woman. Any disagreement in the marriage relationship, the man is to blame. Another thing I don't like in the country is work. I have work 80 hours to survive per week but in African worked only 40 hours to survive."
10SP	"In Africa, men have to go out and marry a woman and have pay bride price. So, when they bring the woman home, they are required to take great care of the woman and to protect her. When any mis-understanding occur in the marriage the man is held accountable. Now the difference with women in America is that women have equal right into the marriage and both partners are held accountable. In addition, another problem in this country is working hours. All I do is work to survive."
11KD	"In Africa, depending on the country, males can marry before the age of 18 years and a female can be just 13 years. Also, in Africa the man is held accountable to greater responsibility of taking care of a woman than in America. What I have seen is that in America the man is not held accountable with greater responsibility of taking care of a woman. Another difference is that both men and woman must be above the age of 18 years before they can marry and that both have equal rights the

marriage relationship. With regards to work, I do a lot of overtime just to bills. Lots of working hours."

12NP "In Africa, men are the custodian of marriage and are held responsible for marrying and taking care of a woman. In America, a woman has equal rights to marry and divorce and I have also seen that women control the house with more power than men. Another problem in this country is too much bills. One has to work lots of overtime to survive."

13CD "In America the marriage relationship is more flexible because of because of equal rights. While in Africa men are held responsible for taking care of the woman and this makes marriage stronger than in America. In addition to marriage problem is that working in America is the only way to survive. It takes a way the fun in life because all I do is work to pay bills. In Africa my routines were more fun because there was no limitation on time … The difference between Africa and America I have seen is that in America must do everything to survive because of financial demands."

14ZD "In Africa men are held responsible to marry a woman and this results in some men to have multiple partners or polygamy. While in America both men and women have an equal right to marriage and it is very difficult to for one partner to have an

extra-marital relationship because both are required to be committed to the marriage relationship. However, another problem is work in this country. Since arriving in the U.S., it is all work, work, work to survive. It is difficult to visit friends and family without appointment. In Africa not everything is money and I went to work with no pressure to survive. In Africa I worked only 8 hours and no overtime … All I do [in the U.S.] is work, sleep and pay bills. Most of my early life in America involved working overtime like a dying person. In Africa my routine was casual, no pressure, just living life and relaxed. In Africa I had a girlfriend I spent most of the time with. I worked part-time and performed house chores."

9. What kind of sexual relationship do you think African-born immigrants would prefer is it with a woman, with a man or both?

1EP	"African men would prefer to sex relationship with a female not with a man."
2SP	Female
3TP	Female
4LP	Female

5KD	Female
6EN	Female
7SP	Female
8KD	Female
9ND	Female
10SP	Female
11KD	Female
12NP	Female
13CD	Female
14ZD	Female

10. Help me to understand what the differences in sexual relationship between Africans who reside in the United States and your home country. Do you think it would be easier to find a sexual partner for a night in the United States or Africa? Maintain a long-term sexual relationship in the United States or Africa? Acquiring a paid sexual partner in the United States or Africa?

1EP	"It would be easier to find a partner for night in Africa --than in America due to poverty and its cheaper. It is easier to have multiple partners in Africa due to cultural acceptance of polygamy, therefore having casual girlfriends is a tolerable behavior."
2SP	"Easier to find a partner in USA for the night than in Africa. In America they always advertise on TV and phone numbers are right there on the screen."

3TP	"Both places so long one has money to pay the woman for the night. My thinking is that African immigrants when they come in USA engage in unsafe sex with the understanding that American women have no sexual transmitted diseases."
4LP	"Easier to have night partner in USA due to TV ads with phone numbers. In most African Countries it would be a taboo to advertise sex publicly on TV."
5KD	"Easier to have woman for the night in Africa due to poverty. In America it may not be easier with the fact that many women are able to work and support themselves."
6EN	"Easier in Africa to have a woman for night because it's cheaper than US financially and affordable due to poverty.
7SP	"Easier to have a woman for night in the USA due to TV advertisement."
8KD	"Easier in the USA because men in Africa are scared because in Africa, they advertise that there is HIV in the community on every national TV station. Due to poverty and a culture that is male dominated and favors male, men can easily monopolize on having many girl-friends."
9ND	"Easier in the USA due to high publicity on TV with ad. In Africa every national tv station advertises that if you have sex casually

you will have a disease, therefore, men are scared to engage in casual sex activity."

10SP "Easier in Africa due to poverty, so long as they're given money."

11KD "Easier in USA due to high TV publicity and it is just one phone call away. African immigrants when they arrive in USA engage in unsafe sex with the thinking that American women have no disease."

12NP "Easier in Africa because of high poverty level."

13CD "Easier in USA due to high level of publicity for sex for money and TV ads." One of my old friends in Africa had 5 girlfriends by pretending that he was going to marry them and the girls fell for it and he ended up having sex with all of them and never married them."

14ZD "Easier in USA due to high publicity on TV with ads and phone numbers already given."

11. In your opinion how do you think that African immigrants contract HIV?

1EP "By having sex without condoms in USA with multiple sex partners.

2SP "By having sex with multiple partners in USA without condoms. These immigrants do not have family here to tell them not engage in this behavior." Just also to be clear I also know one African friend in the community who use condom to prevent

	STD –this is if not sure about the partners Sexual transmitted disease status but most of them do not use condom.”
3TP	“African immigrants do not wear condoms in USA when having sex with multiple partners because they think in USA women do not have HIV. This exposes them to contracting the disease. In addition, it is easy to have multiple sexual partners in America in various cities and states. No one knows that you have multiple partners in different cities compared to Africa where it is difficult to travel from city to city.”
4LP	“African immigrants contract HIV from nightclubs and by having multiple paid partners in USA.”
5KD	“African immigrants contract HIV by having unsafe sex with multiple sex partners in USA because in America there is no advertisement against in unsafe sex compared to Africa. In Africa every radio station announces about unsafe sex because of HIV. In my former African country, some business leaders in the cities are investing into prostitution making it easier to find a woman for night.”
6EN	“African immigrants contract HIV by having unsafe sex in Africa and then come here and infect others.”
7SP	“African immigrants, especially Muslims, don’t have sex in Africa for fear of being stoned. However, when these men come

	to USA, they feel liberated and can have sex with multiple partners or anybody they want without fear of retribution." But I also some African friend who use condom just if not sure about the partners Sexual transmitted disease. I just want to mention that one person I know only started using condom recently because one of her girlfriends told him she was pregnant, but fortunately she miscarried and lost her pregnancy."
8KD	"African immigrants contract HIV in USA by having multiple partners especially by visiting sex clubs." In addition, I also know some African immigrants who use condom just if not sure about the partners Sexual transmitted disease (STD) status." African immigrants contract HIV in USA by having multiple partners that's for sure."
9ND	"African immigrants engage multiples in their sexual activities in USA. In my former country in Moslem communities having a girlfriend was not acceptable and if a relationship exposed both partners can be stoned. Marriage is the only option of having multiple partners."
10SP	"African immigrant practice unsafe sex, engage multiple sexual partners after they enter USA thinking women in America are healthy, can't harbor the disease."

11KD "African immigrants when they arrive in USA engage in unsafe sex with Multiple sex partners thinking that American women have no disease."

12NP "Africa immigrants engage in unsafe sex when they come to visit in Africa and as a result contract the disease and spread it back in America." (unsafe sex in Africa). The other thing, is that the sensual western life style that existed in western countries and related businesses of prostitution are being duplicated in cities in his former country."

13CD "African immigrants practice unsafe sex in USA with multiple partners and end up contracting the disease."

14ZD "African immigrants practice unsafe sex in USA with multiple partners"

12. In your opinion do you think that African immigrants have a higher risk of contracting HIV when they go back to Africa on holiday? Or do you think they risk of contracting HIV in the USA?

1EP "African immigrants have a higher chance of contracting a disease while on holiday in Africa than in America because the infection rate among women is higher."

2SP "African immigrants have higher risk of contracting a disease if they engaged in sex while on holiday." I was brought up in the environment in which I had never seen a woman legs, thighs,

	arms and buttocks and until when I came to the U.S.A, in-fact to be instantaneously be exposed to a woman wearing shots and sports-bra was more than enticing and my friends have fallen in the same trap of lust and sexuality resulting into having multiple sexual partners."
3TP	"African immigrants cannot contract a disease when on holiday in Africa because they are scared of contracting a disease knowing that HIV is everywhere."
4LP	"African immigrants cannot contract a disease while on holiday in Africa because of fear of knowing that they will contract the disease due to high rate of infection on the continent."
5KD	"African men have high risk of contracting a disease both in Africa and in USA if they begin to engage in unsafe sex."
6EN	"Have high risk of contracting disease when they go on holiday."
7SP	"Have higher risk of contracting the disease in America than in Africa because they tend not use condom in America than in Africa."
8KD	"Not easy to contract disease Africa while on holiday because African immigrants know everyone has the disease. Therefore, the highest chance of contracting a disease is in USA."

9ND	"African immigrants have highest risk of contracting a disease in the USA. Immigrants are scared to have sex in Africa because they know they will contract the disease."
10SP	"African immigrants have a highest risk of contracting the disease in the USA because they don't use protection in America, while when they go to Africa, they are scared to have sex with the assumption that every woman might be infected."
11KD	"African immigrants have highest risk of contracting the disease in USA because they assume women are healthy and do not have a disease. When in Africa they know every woman may a chance of carrying the disease."
12NP	"Africa immigrants have the highest risk of contracting HIV in USA."
13CD	"Africa immigrants have the highest risk of contracting HIV in USA. Since I came from a conservative religious country in which women are forced to wear clothes from head to toe, in-fact most us men never had a chance to see a woman to see wearing a tight dress and see the shape of breast and women buttocks it is very exciting to see all that when I came to the U.S. and that enticements resulted into promiscuity."

14ZD "Africa immigrants have the highest risk of contracting HIV in USA."

13. What symptoms do you think the African-born immigrant would begin to recognize that he has contracted HIV infection?

1EP "Weight loss and I don't anything else."

2SP "Weight loss and coughing. I don't know anything else."

3TP "Weight loss but now days it is difficult to tell due to medication and now HIV people can't lose weight."

4LP "Weight loss and fever."

5KD "Weight loss, TB and rashes on the skin."

6EN "Weight loss but because of medication it is difficult to tell."

7SP "Weight loss but now it is difficult to know with medication."

8KD "Skin rashes, weight loss and fever."

9ND "Weight loss and I don't know anything else."

10SP "Weight loss and fever."

11KD "Weight loss."

12NP "Weight loss."

13CD "Weight loss."

14ZD "Weight loss."

14. What social behavioral activities do you think exposes African-born immigrants to contracting HIV?

1EP	"Alcohol and visiting beer clubs creates immoral sexual tendencies both in African and USA."
2SP	"Red light district clubs for women, social gatherings, and nightclub for homosexuals."
3TP	"Mostly visiting alcohol environments, parties, and Red-light district clubs."
4LP	"Sex without condom."
5KD	"African late-night parties, bars with alcohol and when they begin to participate in drugs."
6EN	"Going to African late-night parties and African weddings."
7SP	"Having multiple sexual partners and having sex without condom."
8KD	"African parties, calling TV telephone sexual advertisement numbers. College campus African parties."
9ND	"College African parties and gathering at bars."
10SP	"Bars with alcohol."
11KD	"African parties and going to sex parlor."
12NP	"Unsafe sex practices, visiting red light district house and alcoholic bars."
13CD	"Red light strip clubs."

14ZD "Single strip clubs and African single parties."

15. Thinking about your African friends, do you think that their fear of contracting HIV while living in the United States has affected their attitude towards use of condoms?

1EP "African immigrants don't use condom in America want bare sex. They may use a condom in Africa because they are scared of infection."

2SP "No condom in America."

3TP "No condom in America. African immigrants do not wear condoms in USA because they think in USA women do not have HIV. This exposes them to contracting the disease."

4LP "No condom in America. Only use condom if scared of getting somebody pregnant. Will use condom in Africa."

5KD "No condom in America."

6EN "No condom in America."

7SP "No condom in America."

8KD "No condom in America."

9ND "No condom in America."

10SP "No condom in America, only use condom if they know possibility of pregnancy."

11KD "No condom in America."

12NP "No condom in America."

13CD "No condom in America only if they know partner will get pregnant."

14ZD "No condom in America. African immigrants practice unsafe sex here in America.

16. Is there something else that you would like to add about factors that could potentially expose the African-born immigrant to HIV in the United States?

1EP "African's contract the disease in Africa and then bring it to the United States."

2SP "African's become more promiscuous in the United States. They engage in the risk behavior of drugs, easy access to sex such as brothels, strip clubs. Therefore, they contract the disease right here in America. I was brought up in the environment in which I had never seen a woman legs, thighs, arms and buttocks and until when I came to the U.S.A, in-fact to be instantaneously be exposed to a woman wearing shots and spots-bra was more than enticing and my friends have fallen in the same trap of lust and sexuality resulting into having multiple sexual partners."

3TP "They contract the disease in the United States where they are free of religion, family accountability and cultural freedom. They think they have reached the top of the world where they

	can do anything without accountability. Due to lack of cultural barriers, traditional values, lack of family accountability, easy access to sex phone and broth houses, African immigrants found it easier to expose themselves to sexual risk-taking behavior."
4LP	"They can contract disease very minimally in Africa but largely here in the United States because of they are free from behavioral accountability at home."
5KD	"Very minimal unsafe sex back home on holiday because they know the disease is everywhere. In America they practice unsafe sex without condoms therefore contracting the disease in America. African immigrants contract HIV by having unsafe sex in USA because in America there is no advertisement against in unsafe sex compared to Africa. In Africa every radio station announces about unsafe sex because of HIV."
6EN	"They contract the disease in America due to lack of condoms. In Africa they are scared of contracting the disease so they use condoms."
7SP	"It is easy to have sex here in America compared to Africa. Therefore, they contract the disease here in America and not in Africa. It is not easy to find condoms in America."
8KD	"They contract the disease in the United States. I worked in Africa; companies held weekly meetings about HIV. Since

	coming to the United States, my company does not talk about HIV. Since people are unaware, they think there is no HIV in America and contract the disease."
9ND	"HIV is contracted in America and not in Africa."
10SP	"They contract the disease in Africa because of blood transfusions and too many women have HIV."
11KD	"They contract the disease in the United States because they don't use condoms here. The idea of polygamy in the culture strengthens the desire to have many sexual partners without retribution."
12NP	"Drugs, and alcohol contribute as risk factors to HIV when immigrants come to the United States. However, they contract the disease when they go back on holiday and have sex without condoms."
13CD	"It is easy to have multiple sexual partners in America in various cities and states. No one knows that you have multiple partners in different cities compared to Africa where it is difficult to travel from city to city. Also since I came from a conservative religious country in which women are forced to where clothes from head to toe, in-fact most us men never had a chance to see a woman wearing a tight dress and see the shape of breast and

women buttocks it is very exciting to see all that when I came to the U.S. and that enticements resulted into promiscuity."

14ZD "Immigrant people are not very educated about HIV. They are not told about the danger of contracting the disease when they come to America. They should be told before they come by the embassies or immigration officers before they immigrate. Therefore, they contract HIV in the United States because they are unaware. It is easy to have unsafe sex in America. In addition, first generation immigrants cannot come with the diseases from Africa due to increased awareness and American embassies in third world countries still send first travelers to US to be screened for diseases and those who are positive for any disease are not permitted to travel. Therefore, African immigrants who come to the United States who do not come with the disease from Africa, consequently, if they have disease, they must have contracted disease here in the United States.

Appendix C: Informational Flyer

Be part of an extensive male African-born immigrant (Sub-Saharan) with HIV/AID research study.

- Are you an African-born male resident?
- Are you 18 years of age or older?
- Did you contracted HIV while living in the United States
- Do you live in Pennsylvania, New Jersey, Delaware or New York

If your response was “YES “ to the above questions you are privileged to participate in focus group discussion related to “real life experience of how African-born immigrants (Sub-Saharans) contract HIV/AIDS while living in the United States. In addition, if you know someone else who can qualify to take part in this study, please free to refer that person to the researcher.

The objective of this research study is to analyze the attitudes, knowledge, beliefs and behaviors relates to “life experiences HIV/AIDS positive male African-born U.S. residents went through in order to contract HIV/AIDS. Participation in this research study is factually voluntary. All communication and information related to this study will be confidential and no names will be utilized in the subsequent reports or data. To know more about this study, feel free to call Henry at 484-802-8414. The principle researcher for this study will be Henry Sinyangwe, Walden University Ph.D. candidate.

The people who volunteer to participate in this study will be given a travel voucher, gift bag, $10 gift card and refreshments will be served to those in attendance.

Appendix D: Semi-structured Interview Questions

Research Questions: What factors expose Sub-Saharan male African-born U.S. residents to contract HIV/AIDS while living in the United States?

1. RQ1 – Qualitative: What is the perceived susceptibility that predisposes Sub-Saharan Male African Immigrants to sexual risk-taking behaviors when they come to the United States?
2. RQ2 – Qualitative: What are the perceived cultural safeguards (cultural, social, and economic) that existed in Africa that are absent in the U.S. and has exposed African-born U.S. residents to HIV?
3. RQ3 – Qualitative: What does the African immigrant male perceive to be dissonant in the U.S. culture that promoted risk-taking behavior? [Cultural dissonance is an uncomfortable sense of discord, disharmony, confusion, or conflict experienced by people in the midst of change in their cultural environment].

Semi-structured Interview Questions

1. Explain your life experience after you had just Arrived in the United States as an Immigrant.
2. After arriving in the United States what were the daily routine experiences you began to perform?
3. Did you need to look for a job immediately upon arrival or did you get financial support to sustain you?
4. What was your social support group and how did they provide for your needs?

5. What were the strengths and weaknesses of your support group?
6. Tell me some places that your African friends go to socialize?
7. Tell me how your social activities that have changed since coming to the United States compared to how you socialized in Africa?
8. What are the differences between the male and female relationships in America compared to Africa?
9. What kind of sexual relationship do you think African-born immigrants would prefer, with men, women or both?
10. Help me understand what are differences between sexual relationships between Africans who reside in the United States and your home country. Do you think it would be easier to find a sexual partner for a night in the United States or Africa? Would you maintain a long-term sexual relationship in the United States or in Africa? Would it be easier acquiring a paid sexual partner in the United States or Africa?
11. In your opinion, how do you think African immigrants contract HIV?
12. In your opinion do you think that African immigrants have a higher risk of contracting HIV when they go back to Africa on holiday? Or do you think they have a higher risk of contracting HIV in the USA?
13. What symptoms do you think the African-born male immigrant would display to show that he has contracted the HIV infection?
14. What social behavioral activities expose African male immigrants to HIV?

15. Thinking about your African friends, do you think that their fear of contracting HIV while in the United States has affected their attitude towards use of condoms?
16. Is there something else that you would like to add about factors that would potentially expose African-born immigrants to HIV?

Appendix E: Facilitator Guide

1. Welcome and introduction:

    - Facilitator/Note Taker

II. Informed-Consent Process

In the presence of the study participants, I will examine the informed consent process by reviewing its significance and then I will obtain the signature from the subjects.

III. Purpose

The objective of this meeting with you as a study participant is to explore factors that expose African born immigrants to contracting HIV by exploring your attitudes, knowledge, beliefs and behaviors. Research findings from this study will be utilized to address the responsibility of primary prevention strategy among current and future Sub-Saharan African immigrants who have not yet been infected with HIV. Prevention strategies among Sub-Saharan African U.S. residents may include designing and implementing specific targeted preventive initiative distinct to this respective community. This study selected semi-structure interview process for each subject to deduce definitive detailed private personal influencing factors that exposed them to contracting HIV from life experience. The significance of audio recorder is to permit annotation of your comments to scrupulously examine the data. No other than the principle investigator will be exposed to recorded tapes. All names mentioned during the interview will be eliminated from entire transcripts. I must emphasize that participation in this research study is voluntary, research subjects are to choose to be involved in the research or

abdicate at any moment.

IV. Procedure

Based on the grounded theory being utilized in this study there will be two interviews conducted for each participant to examine correlation of statements regarding factors that influenced to contracting HIV. Each session for this semi-structured interview will last for an hour. I would like to encourage you to speak clearly, sincerely and openly about feelings and lived experience knowing that at the end of this study other lives will be saved because of your voluntary sacrifice. Furthermore, it is wise to remember if you do not understand the question correctly ask for clarification and just answer the question based on your cultural values, knowledge, attitude, behavior and life experiences. Do you have anything else to add, comments or questions?

V. Participant introduction:

In the next 5 minutes while the tape recorder is off I will allow that we just talk on other subjects just to familiarize to each other and build rapport

IV. Collect Demographic data

At this time I will turn the recorder on to start getting insight into your life experiences. I will begin by asking a question.

Discussion: please See Appendix D

End of the interview

- Thank research participants for volunteering for the study and for participating
- Remind the participants about confidentiality and consent
- Note that issue of indicated compensation for participating in the study.

Appendix F: Demographic Data Questionnaire

1. Date of birth---------- City ---------- Country--------
2. Ethnicity----------
3. Current age: ----------
4. Marital status

   _____Now married----------years

   _____Widowed----------years

   _____Divorced----------years

   _____Separated----------years

   _____Never Married----------years

   _____Single----------years

   _____Has Girl Friend----------years.
5. What is the highest degree or level of school you have completed

   _____No schooling completed

   _____4^{th}, 5^{th} 6^{th} 7^{th} 8^{th} 9^{th} 10^{th}, 11^{th} grade

   _____High school graduate or GED

   _____Some College credits, but no degree

   _____Associate degree

   _____Bachelor’s degree

   _____Master’s degree

   _____Professional degree

   _____Doctorate degree

5. Employment Status

   _____Employed for wages

   _____Self-employed

   _____Unemployed

   _____A homemaker

   _____A student

   _____ Retired

   _____Unable to work

6. What is your total household income

   ____Less than $10,000

   ____$10,000 to $19,999

   ____$30,000 to 39,999

   ____$40,000 to $ 49,999

   ____$50,000 to $ 59,999

   ____$60,000 to more

7. State in which you reside

   ____Pennsylvania

   ____New Jersey

   ____Delaware

   ____New York

8. How long have you been aware of your current HIV status? _____

9. How did you contract HIV?

____Unprotected sexual intercourse

____Injection drug use

____From an infected mother

____Blood transfusion/organ transplant

____I don't know

10. In which country did you contract HIV?

____Home country (List country) _____

____United States (Indicate State and City)_____